Indiana State Department of Health

Division of Long Term Care

TELEPHONE GUIDE

Arranged alphabetically by subject

All are Area Code 317 **9/7/06**

SUBJECT	CONTACT PERSON	EXTENSION
Assistant Commissioner, Health Care Regulatory Services	Terry Whitson	233-7022
Director, Division of Long Term Care	Suzanne Hornstein	233-7289
Administrator/DON, Facility Name/Address Changes	Seth Brooke	233-7794
Bed Change Requests (Changing/Adding Licensed Bed/Classifications)	Seth Brooke	233-7794
CNA Registry	Automated	233-7612
CNA Investigations	Zetra Allen	233-7772
CNA/QMA Training	Nancy Adams	233-7480
Consultant Program	Michael Dean	233-7784
Enforcement & Remedies	Miriam Buffington	233-7613
Facility Data Inquiries	Sarah Roe	233-7904
FAX, Administration		233-7322
Incidents/Unusual Occurrences	Fax Voicemail Other	233-7494 233-5359 233-7442
Informal Dispute Resolution	Susie Scott	233-7651
License/Ownership Verification Information	Seth Brooke	233-7794
License Renewal	Seth Brooke	233-7794
Licensed Facility Files (Review/Copies)	Darlene Jones	233-7351
Licensure & Certification Applications/Procedures (for New Facilities and Changes of Ownership)	Seth Brooke	233-7794
Life Safety Code	Rick Powers	233-7471
MDS/RAI Clinical Help Desk	Gina Berkshire	233-4719
MDS/OASIS Technical Help Desk	Technical Help Desk Staff	233-7206
Monitor Program	Debbie Beers	233-7067
Plans of Correction (POC), POC Extensions & Addenda	Area Supervisors	See Below
Plans & Specifications Approval (New Construction & Remodeling)	Dennis Ehlers	233-7588
Reporting	Tom Reed	233-7541
Rules & Regulations	Debbie Beers	233-7067
Survey Manager	Kim Rhoades	233-7497
Transfer/Discharge of Residents	Seth Brooke	233-7794
Unlicensed Homes/Facilities	Linda Chase	233-7095
Waivers (Rule/Room Size Variance/Nursing Services Variance)	Seth Brooke	233-7794
Web Site Information	Sarah Roe	233-7904
AREA SUPERVISORS		
Area 1	Judi Navarro	233-7617
Area 2	Brenda Meredith	233-7321
Area 3	Brenda Buroker	233-7080
Area 4	Zetra Allen	233-7772
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR North	Chris Greeney	233-7894
ICF/MR South	Steve Corya	233-7561

Annual Reporting Requirement

410 IAC 16.2-3.1-13 (o) requires that each nursing facility submit an annual statistical report to the Indiana State Department of Health.

The Department has made some adjustments to the program. The annual reporting requirement questionnaire will no long be distributed on a diskette. Instead there will be two options provided for facilities:

- Complete the "Annual Report Questionnaire" in Microsoft Excel and then submit the completed questionnaire to the ISDH via email. The instructions for locating, opening, and submitting the Microsoft Excel "Annual Report Questionnaire" file can be found below. Instructions for opening and submitting can be found below. This is the preferred method.

- Complete the "Annual Report Questionnaire" in Microsoft Word or complete a hard copy of the questionnaire and submit via mail. The Microsoft Word "Annual Report Questionnaire" file can be found below. Instructions for opening and submitting can be found below.

NOTE: Please note that there is a file containing the Annual Report Instructions below. Please carefully follow these instructions when completing the questionnaire.

Instructions for Opening the Annual Report Instructions

- Right click on the link titled "Annual Report Instructions
- Select "Save Target As"
- Save the file as "Annual Report Instructions"
- Select "Save"
- Select "Open"
- The Annual Report Instructions will now be open for review

Instructions for Opening the Annual Report Questionnaire

- Right click on the link for the Microsoft Word or Microsoft Excel (preferred method) file titled "Annual Report Questionnaire"
- Select "Save Target As"
- Save the file as "Annual Report Questionnaire"
- Select "Save"
- Select "Open"
- The Annual Report Questionnaire will now be open for completion

Instructions for Completing the Annual Report Questionnaire

- Save and open the files titled "Annual Report Instructions" and "Annual Report Questionnaire" as directed above
- The filed titled "Annual Report Instructions" will contain the instructions necessary for the completion of the Annual Report Questionnaire. Review and follow the Annual Report Instructions carefully.
- Fill out the Annual Report Questionnaire. Please ensure that all fields are populated.
- Save the questionnaire as "Annual Report Questionnaire".
- Print out a copy of the questionnaire for facility records.
- Submit the "Annual Report Questionnaire" to the Indiana State Department of Health. There are two methods: mail or email. Submission via email is the preferred method.

Indiana State Department of Health
Attn: Program Director-Provider Services
2 N Meridian St.
Indianapolis, IN 462004
Email to: sbrooke@isdh.in.gov

The questionnaire for fiscal year 2005 will be ready to complete in September 2006. Then beginning in 2007, the questionnaire will be ready for completion in March. Each nursing facility is expected to submit the statistical report within sixty (60) days of its request. For more information please contact the Program Director-Provider Services in the Division of Long Term Care at 317-233-7794.

For more information, contact:

Division of Long Term Care
317/233-7794

Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

Indiana State
Department of Health
An Equal Opportunity Employer

September 1, 2006

Long Term Care Administrator

RE: 2005 Annual Report of Comprehensive Care Facilities

Dear Administrator:

In accordance with 410 IAC 16.2-3.1-13 (o), each health facility must submit an annual statistical report to the Indiana State Department of Health.

The Indiana State Department of Health has made some adjustments to the program this year. The annual report instructions and annual report questionnaire will now be found on-line. The questionnaire is now a Microsoft Excel file that can be saved, opened, and completed via the Indiana State Department of Health web-site and submitted to the Program Director-Provider Services via mail or e-mail.

Enclosed in this mailing are the annual report instructions form and a Microsoft Word version of the annual reporting questionnaire. The Annual Report Instructions packet contains the instructions for locating the Annual Report Questionnaire on the Indiana State Department of Health website and then completing and submitting the Annual Report Questionnaire.

Please complete the Annual Report Questionnaire and return to the Indiana State Department of Health via mail or email by October 31, 2006. Any questions regarding the annual report may be addressed to the Program Director-Provider Services at 317-233-7794.

Sincerely,

Sue Hornstein, Director
Division of Long Term Care

Annual Report of Comprehensive Long Term Care Facilities
Report Instructions

Data Table One: Facility Information

The first data table seeks to collect basic facility information. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Medicare Provider Number**:
  Enter the Medicare Provider and/or Medicaid Vendor number assigned to the facility. This number will begin with either: 155 or 15E.
- **Facility Name**:
  Enter the most recent facility name reported to the Indiana State Department of Health.
- **Street Address**:
  Enter the current street address of the long term care facility. This address should not be the mailing address.
- **City**:
  Enter the city in which the long term care facility is located.
- **Zip Code**:
  Enter the zip code assigned to the city and street address by the United States Postal Service.
- **County**:
  Enter the county in which the long term care facility is located.

Data Table One

Facility Information	
Medicare Provider Number	Enter Data
Facility Name	Enter Data
Street Address	Enter Data
City	Enter Data
Zip Code	Enter Data
County	Enter Data

Data Table Two: Type of Specialized Units

The second data table seeks to collect information on the number of beds and bed census in five different specialized unit types. There are five specialized unit types: HIV Unit, Dementia Special Care Unit, Head Trauma Unit, Pediatric Unit, and Ventilator Unit. For each of these five specialty types there are two questions: number of beds and bed census as of December 31st, 2005. If the facility have no specialized units or no units of a specific category please list zero "0" as the total for each question. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Number of Beds Column**: This column should be filled with the total number of beds the long term care facility has designated at specialized in that particular category.
- **Bed Census as of December 31st, 2005 Column**: This column should contain the total number of residents residing in the specialized unit.
- **Definition of Specialized Units**: Specialized Unit is a facility-designated unit with beds within a comprehensive care facility which have been specifically dedicated to providing one special type of care that is used solely for a resident who has been diagnosed with the following specific conditions:

    - **HIV Unit** refers to those units treating residents infected by the human immunodeficiency virus (HIV).
    - **Dementia Special Care Unit** refers to a facility-based self-designated unit for the treatment of residents with Alzheimer's disease.
    - **Head Trauma Unit** refers to those units treating residents with a medically stable brain and high spinal cord injury or a resident with a major progressive neuromuscular disease.
    - **Pediatric Unit** refers to those facilities or units which provide nursing care, rehabilitative procedures, room, food, and laundry for children less than 18 years who, because of their diagnosis, require such care.
    - **Ventilator Unit** refers to those units treating residents on mechanical ventilators that are medically stable twelve to twenty-four hours each day.

Data Table Two

Type of Specialized Units		
	Number of Beds	**Bed Census as of December 31st, 2005**
AIDS Unit	Enter Data	Enter Data
Dementia Special Care Unit	Enter Data	Enter Data
Head Trauma Unit	Enter Data	Enter Data
Pediatric Unit	Enter Data	Enter Data
Ventilator Unit	Enter Data	Enter Data

Data Table Three: Bed Count by Type

The third data table seeks to collect the bed census in each of the five long term care bed categories as of December 31st, 2005. Bed census can be defined as actual number of residents residing, per bed, in a facility. The five bed categories are: Medicare/Medicaid Dually Certified, Medicare Only, Medicaid Only, Non-Certified Comprehensive, and Residential. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Medicare/Medicaid Dually Certified (Title 18 SNF/Title 19 NF)**
  Enter the total bed census for beds certified for participation in both the Medicare and Medicaid programs as of December 31st, 2005.
- **Medicare only (Title 18 SNF)**
  Enter the total bed census for beds certified for participation in the Medicare program as of December 31st, 2005.
- **Medicaid only (Title 19 NF)**
  Enter the total bed census for beds certified for participation in the Medicaid program as of December 31st, 2005.
- **Non-Certified Comprehensive (NCC)**
  Enter the total bed census for beds that are not reimbursed under Medicare or Medicaid, but that are licensed comprehensive by the Indiana State Department of Health as of December 31st, 2005. These rooms are generally private pay.
- **Residential**
  Enter the total bed census for beds at are state licensed residential as of December 31st, 2005.

Data Table Three

Bed Census by Type	
	Bed Census as of December 31st, 2005
Medicare/Medicaid Certified	Enter Data
Medicare Only	Enter Data
Medicaid Only	Enter Data
Non-Certified Comprehensive	Enter Data
Residential	Enter Data
Total Certified Beds	0
Total Licenses Beds	0

Data Table Four: Bed Capacity by Type

The forth data table seeks to collect the bed capacity by bed type acknowledged by the Indiana State Department of Health at the facility as of December 31st, 2005. The five bed type categories are: Medicare/Medicaid Dually Certified, Medicare Only, Medicaid Only, Non-Certified Comprehensive, and Residential. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Medicare/Medicaid Dually Certified (Title 18 SNF/Title 19 NF)**
  Enter the total bed capacity for beds certified for participation in both the Medicare and Medicaid programs as of December 31st, 2005.
- **Medicare only (Title 18 SNF)**
  Enter the total bed capacity for beds certified for participation in the Medicare program as of December 31st, 2005.
- **Medicaid only (Title 19 NF)**
  Enter the total bed capacity for beds certified for participation in the Medicaid program as of December 31st, 2005.
- **Non-Certified Comprehensive (NCC)**
  Enter the total bed capacity for beds that are not reimbursed under Medicare or Medicaid, but that are licensed comprehensive by the Indiana State Department of Health as of December 31st, 2005. These rooms are generally private pay.
- **Residential**
  Enter the total bed capacity for beds that are state licensed residential as of December 31st, 2005.

Data Table Four

Bed Capacity by Type	
	Bed Capacity as of December 31st, 2005
Medicare/Medicaid Certified	Enter Data
Medicare Only	Enter Data
Medicaid Only	Enter Data
Non-Certified Comprehensive	Enter Data
Residential	Enter Data
Total Certified Beds	0
Total Licenses Beds	0

Data Table Five: Resident Days by Bed Type

The fifth data table seeks to collect the total number of resident days by bed classification type during the period from January 1st, 2005 until December 31st, 2005. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Resident Days**
  Resident days are the total days for all residents. The total of one resident's resident day is calculated by totaling the number of days in calendar year (including day of admission and day of discharge) that he or she resides and is treated in the facility. The total fields will automatically add these fields.
- **Medicare/Medicaid Dually Certified (Title 18 SNF/Title 19 NF)**
  Enter the total number of resident days for beds certified for participation in both the Medicare and Medicaid programs during the period from January 1st, 2005 until December 31st, 2005.
- **Medicare only (Title 18 SNF)**
  Enter the total number of resident days for beds certified for participation in the Medicare program during the period from January 1st, 2005 until December 31st, 2005.
- **Medicaid only (Title 19 NF)**
  Enter the total number of resident days for beds certified for participation in the Medicaid program during the period from January 1st, 2005 until December 31st, 2005.
- **Non-Certified Comprehensive (NCC)**
  Enter the total number of resident days for beds that are not reimbursed under Medicare or Medicaid, but that are licensed comprehensive by the Indiana State Department of Health during the period from January 1st, 2005 until December 31st, 2005. These rooms are generally private pay.
- **Residential**
  Enter the total number of resident days for beds at are state licensed residential during the period from January 1st, 2005 until December 31st, 2005.

Data Table Five

Resident Days by Bed Type	
Number of Resident Days From January 1, 2005-December 31, 2005	
Medicare/Medicaid Certified	Enter Data
Medicare Only	Enter Data
Medicaid Only	Enter Data
Non-Certified Comprehensive	Enter Data
Residential	Enter Data
Total Certified Beds	0
Total Licenses Beds	0

Data Table Six: Resident Days by Bed Type and Age From January 1, 2005-December 31, 2005

The sixth data table seeks to collect the total number of resident days by bed classification type by age during the period from January 1st, 2005 until December 31st, 2005. There are five age periods: under sixty-five (65) years of age, sixty-five (65) to seventy-four (74) years of age, seventy-five (75) to eighty-four (84) years of age, and above eighty-five (85) years of age. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Resident Days**: Resident days are the total days for all residents. The total of one resident's resident day is calculated by totaling the number of days in calendar year (including day of admission and day of discharge) that he or she resides and is treated in the facility. The total fields will automatically add these fields.
- **Medicare/Medicaid Dually Certified (Title 18 SNF/Title 19 NF)**
  Enter the total number of resident days by age for beds certified for participation in both the Medicare and Medicaid programs during the period from January 1st, 2005 until December 31st, 2005.
- **Medicare only (Title 18 SNF)**
  Enter the total number of resident days by age for beds certified for participation in the Medicare program during the period from January 1st, 2005 until December 31st, 2005.
- **Medicaid only (Title 19 NF)**
  Enter the total number of resident days by age for beds certified for participation in the Medicaid program during the period from January 1st, 2005 until December 31st, 2005.
- **Non-Certified Comprehensive (NCC)**
  Enter the total number of resident days by age for beds that are not reimbursed under Medicare or Medicaid, but that are licensed comprehensive by the ISDH during the period from January 1st, 2005 until December 31st, 2005.
- **Residential:** Enter the total number of resident days by age for beds at are licensed residential during the period from January 1st, 2005 until December 31st, 2005.

Data Table Six

Resident Days by Bed Type and Age From January 1, 2005-December 31, 2005					
	Under 65 Years	**65-74 Years**	**75-84 Years**	**85+ Years**	**Total**
Medicare/Medicaid Certified	Enter Data	Enter Data	Enter Data	Enter Data	0
Medicare Only	Enter Data	Enter Data	Enter Data	Enter Data	0
Medicaid Only	Enter Data	Enter Data	Enter Data	Enter Data	0
Non-Certified Comprehensive	Enter Data	Enter Data	Enter Data	Enter Data	0
Residential	Enter Data	Enter Data	Enter Data	Enter Data	0
Total Certified Beds	0	0	0	0	0
Total Licenses Beds	0	0	0	0	0

Data Table Seven: Comprehensive Level Care Resident Demographics From January 1st, 2005-December 31st, 2005.

The seventh data table seeks some basic demographic information on residents in beds deemed comprehensive. Comprehensive level care bed designations would include the following bed category types: Medicare/Medicaid Dually Certified, Medicare Only, Medicaid Only, and Non-Certified Comprehensive. The data table is seeking demographic information on those residents in two categories: age and gender. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- Age by Gender
  - Enter the total number of comprehensive level care residents for each age group by gender. The age categories are as follows: zero to nineteen (0-19) years old, twenty to thirty-nine (20-39) years old, forty to sixty-four (40-64) years old, sixty-five to seventy-four (65-74) years old, seventy-five to eighty-four (75-84) years old, and above eighty-five years old. The gender categories are as follows: male and female.

Data Table Seven

Comprehensive Level Care Resident Demographics From January 1, 2005-December 31, 2005			
Age Group	**Male**	**Female**	**Total**
0-19 Years	Enter Data	Enter Data	0
20-39 Years	Enter Data	Enter Data	0
40-64 Years	Enter Data	Enter Data	0
65-74 Years	Enter Data	Enter Data	0
75-84 Years	Enter Data	Enter Data	0
85+ Years	Enter Data	Enter Data	0
Total	0	0	0

Data Table Eight: Admissions by Referral Source From January 1st, 2005-December 31st, 2005

The eighth data table seeks information on the facility admission source for residents admitted to the facility during the period from January 1st, 2005 until December 31st, 2005. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Independent/Self Care**:
  Enter the total number of times that an individual, under their own recognizance, admits themselves into the facility during the period from January 1st, 2005 until December 31st, 2005.
- **Family:**
  Enter the total number of times that a family, or power of attorney, admits a resident into the facility during the period from January 1st, 2005 until December 31st, 2005.
- **Hospital:**
  Enter the total number of times that a hospital admits a resident into the facility during the period from January 1st, 2005 until December 31st, 2005.
- **Mental Health Center:**
  Enter the total number of times that a mental health facility admits a resident into the facility during the period from January 1st, 2005 until December 31st, 2005.
- **Home Health Agency**:
  Enter the total number of times that a home health agency admits a resident into the facility during the period from January 1st, 2005 until December 31st, 2005.
- **Another Nursing Facility:**
  Enter the total number of times that another nursing facility admits a resident into the facility during the period form January 1st, 2005 until December 31st, 2005.
- **Other:**
  Enter the total number of times that any other admission source type was utilized during the period from January 1st, 2005 until December 31st, 2005.

Data Table Eight

Admissions by Referral Source From January 1, 2005-December 31, 2005	
Admission Source Type	**Total Number of Residents**
Independent/Self Care	Enter Data
Family	Enter Data
Hospital	Enter Data
Mental Health Center	Enter Data
Home Health Agency	Enter Data
Another Nursing Facility	Enter Data
Other	Enter Data

Data Table Nine: Facility Discharges by Types from January 1st, 2005 until December 31st, 2005

The ninth data table seeks information on facility discharges for residents discharged during the period from January 1st, 2005 until December 31st, 2005. Directions and definitions for the fields required for completion in this data table are listed and defined below.

- **Discharged to Self-Care**
  Enter the total number of times that a resident was discharged to care for themselves during the period from January 1st, 2005 until December 31st, 2005.
- **Discharged to Family**
  Enter the total number of times that a resident was discharged to be cared for by their facility during the period from January 1st, 2005 until December 31st, 2005.
- **Discharged to Hospital**
  Enter the total number of times that a resident was discharged to be cared for by a hospital or another health care facility during the period from January 1st, 2005 until December 31st, 2005.
- **Discharged to Mental Health Facility**
  Enter the total number of times that a resident was discharged to be cared for by a mental health facility during the period from January 1st, 2005 until December 31st, 2005.
- **Discharged to Another Nursing Facility**
  Enter the total number of times that a resident was discharged to be cared for by another nursing facility during the period from January 1st, 2005 until December 31st, 2005.
- **Death**
  Enter the total number of times that a resident died in the facility during the period from January 1st, 2005 until December 31st, 2005.
- **Other Discharges**
  Enter the total number of times that a resident was discharged for any other reason during the period from January 1st, 2005 until December 31st, 2005.

Data Table Nine

Discharges by Type From January 1, 2005-December 31, 2005	
Discharge Type	**Total Number of Residents**
Discharged to Self-Care	Enter Data
Discharged to Family	Enter Data
Discharged to Hospital	Enter Data
Discharged to Mental Health	Enter Data
Discharged to Nursing Facility	Enter Data
Death	Enter Data
Other Discharges	Enter Data

Annual Report Questionnaire

In accordance with 410 IAC 16.2-3.1-13 (o), each health facility must submit an annual statistical report to the Indiana State Department of Health. The Annual Report Questionnaire can be found below. The Annual Report Instructions packet contains the instructions for completing and submitting the Annual Report Questionnaire. Please follow these instructions carefully.

Complete the Annual Report Questionnaire and return to the Indiana State Department of Health via mail or email by October 31, 2006. Any questions regarding the annual report may be addressed to the Program Director-Provider Services at 317-233-7794.

Facility Information	
Medicare Provider Number	
Facility Name	
Street Address	
City	
Zip Code	
County	

Type of Specialized Units		
	Number of Beds	**Bed Census as of December 31st, 2005**
AIDS Unit		
Dementia Special Care Unit		
Head Trauma Unit		
Pediatric Unit		
Ventilator Unit		

Bed Census by Type	
	Bed Census as of December 31st, 2005
Medicare/Medicaid Certified	
Medicare Only	
Medicaid Only	
Non-Certified Comprehensive	
Residential	
Total Certified Beds	
Total Licenses Beds	

Bed Capacity by Type	
	Bed Capacity as of December 31st, 2005
Medicare/Medicaid Certified	
Medicare Only	
Medicaid Only	
Non-Certified Comprehensive	
Residential	
Total Certified Beds	
Total Licenses Beds	

Resident Days by Bed Type	
Number of Resident Days From January 1, 2005-December 31, 2005	
Medicare/Medicaid Certified	
Medicare Only	
Medicaid Only	
Non-Certified Comprehensive	
Residential	
Total Certified Beds	
Total Licenses Beds	

Resident Days by Bed Type and Age From January 1, 2005-December 31, 2005					
	Under 65 Years	65-74 Years	75-84 Years	85+ Years	Total
Medicare/Medicaid Certified					
Medicare Only					
Medicaid Only					
Non-Certified Comprehensive					
Residential					
Total Certified Beds					
Total Licenses Beds					

Comprehensive Level Care Resident Demographics From January 1, 2005-December 31, 2005			
Age Group	Male	Female	Total
0-19 Years			
20-39 Years			
40-64 Years			
65-74 Years			
75-84 Years			
85+ Years			
Total			

Admissions by Referral Source From January 1, 2005-December 31, 2005	
Admission Source Type	**Total Number of Residents**
Independent/Self Care	
Family	
Hospital	
Mental Health Center	
Home Health Agency	
Another Nursing Facility	
Other	

Discharges by Type From January 1, 2005-December 31, 2005	
Discharge Type	**Total Number of Residents**
Discharged to Self-Care	
Discharged to Family	
Discharged to Hospital	
Discharged to Mental Health	
Discharged to Nursing Facility	
Death	
Other Discharges	

Thank you completing the Annual Report Questionnaire. If the facility has decided to complete the paper copy, please submit a copy of the completed form via mail to:

Indiana State Department of Health
Attn: Program Director-Provider Services
Section 4B
2 N Meridian
Indianapolis, IN 46204

Annual Report Questionnaire

In accordance with 410 IAC 16.2-3.1-13 (o), each health facility must submit an annual statistical report to the Indiana State Department of Health. The Annual Report Questionnaire can be found below. The Annual Report Instructions packet contains the instructions for completing and submitting the Annual Report Questionnaire. Please follow these instructions carefully.

Complete the Annual Report Questionnaire and return to the Indiana State Department of Health via mail or email by October 31, 2006. Any questions regarding the annual report may be addressed to the Program Director-Provider Services at 317-233-7794.

Facility Information	
Medicare Provider Number	
Facility Name	
Street Address	
City	
Zip Code	
County	

Type of Specialized Units		
	Number of Beds	**Bed Census as of December 31st, 2005**
AIDS Unit		
Dementia Special Care Unit		
Head Trauma Unit		
Pediatric Unit		
Ventilator Unit		

Bed Census by Type	
	Bed Census as of December 31st, 2005
Medicare/Medicaid Certified	
Medicare Only	
Medicaid Only	
Non-Certified Comprehensive	
Residential	
Total Certified Beds	
Total Licenses Beds	

Bed Capacity by Type	
	Bed Capacity as of December 31st, 2005
Medicare/Medicaid Certified	
Medicare Only	
Medicaid Only	
Non-Certified Comprehensive	
Residential	
Total Certified Beds	
Total Licenses Beds	

Resident Days by Bed Type	
Number of Resident Days From January 1, 2005-December 31, 2005	
Medicare/Medicaid Certified	
Medicare Only	
Medicaid Only	
Non-Certified Comprehensive	
Residential	
Total Certified Beds	
Total Licenses Beds	

Resident Days by Bed Type and Age From January 1, 2005-December 31, 2005					
	Under 65 Years	65-74 Years	75-84 Years	85+ Years	Total
Medicare/Medicaid Certified					
Medicare Only					
Medicaid Only					
Non-Certified Comprehensive					
Residential					
Total Certified Beds					
Total Licenses Beds					

Comprehensive Level Care Resident Demographics From January 1, 2005-December 31, 2005			
Age Group	Male	Female	Total
0-19 Years			
20-39 Years			
40-64 Years			
65-74 Years			
75-84 Years			
85+ Years			
Total			

Admissions by Referral Source From January 1, 2005-December 31, 2005	
Admission Source Type	**Total Number of Residents**
Independent/Self Care	
Family	
Hospital	
Mental Health Center	
Home Health Agency	
Another Nursing Facility	
Other	

Discharges by Type From January 1, 2005-December 31, 2005	
Discharge Type	**Total Number of Residents**
Discharged to Self-Care	
Discharged to Family	
Discharged to Hospital	
Discharged to Mental Health	
Discharged to Nursing Facility	
Death	
Other Discharges	

Thank you completing the Annual Report Questionnaire. If the facility has decided to complete the paper copy, please submit a copy of the completed form via mail to:

Indiana State Department of Health
Attn: Program Director-Provider Services
Section 4B
2 N Meridian
Indianapolis, IN 46204

Bed Change Requests

Facilities may elect to request changes in state licensed (Residential or NCC) or certified comprehensive (Title 18 SNF, Title 19 NF, Title 18 SNF/Title 19 NF) bed configuration beds in accordance with state and federal rules/regulations. The following bed classifications should be used in all correspondence concerning your facility's request for change in bed configuration:

Title 18 SNF	Medicare only
Title 18 SNF/Title 19 NF	Dually Certified for Medicare and Medicaid
Title 19 NF	Medicaid only
NCC	Non-Certified Comprehensive (Not reimbursed under Medicare or Medicaid)-Private Pay
Residential	Private Pay (unless approved by Room, Board and Assistance (RBA) program by Medicaid or receives a Medicaid Waiver)

To request a change in bed configuration please contact the Program Director-Provider Services at 317-233-7794.

Residential

Bed change requests involving Residential Level of Care beds will be processed under the following guidelines. The effective date for these bed changes is the date requested by the provider but not earlier than the date the request is filed with (received in) the Division of Long Term Care. Bed changes are not approved retroactively. If the bed change is the result of new construction in which either a Life Safety Code, State Fire Code or Sanitarian Inspection is required, the effective date of the bed change will be the date that these inspections are released and you are authorized to occupy the area.

Non-Certified Comprehensive (NCC)

Bed change requests involving Non-Certified Comprehensive Level of Care beds will be processed under the following guidelines. The effective date for these bed changes is the date requested by the provider but not earlier than the date the request is filed with (received in) the Division of Long Term Care. Bed changes are not approved retroactively. If the bed change is the result of new construction in which either a Life Safety Code, State Fire Code or Sanitarian Inspection is required, the effective date of the bed change will be the date that these inspections are released and you are authorized to occupy the area.

Title 18 SNF, Title 19 NF, and Title 18 SNF/Title 19 NF

Facilities may elect to change the number of beds that are certified to participate in the Medicare and/or Medicaid programs in accordance with the guidelines published in the Centers for Medicare and Medicaid Services ("CMS") State Operations Manual ("SOM"), Section 3202:

Frequency

- Distinct Part Bed Size changes may occur up to two (2) times per cost reporting year: Once on the first day of the cost reporting year, and once on the first day of a single cost reporting quarter within that same cost reporting year.
- If a facility chooses not to affect a Distinct Part Bed Size change on the first day of its cost reporting year, it loses that opportunity for a change, and has only one (1) remaining change available for that cost reporting year.
- At no time can a facility affect two (2) decreases in Distinct Part Bed Size during the same cost reporting year.
- Exceptions:
    - If the request for change in Distinct Part Bed Size is made to avoid non-compliance with Life Safety Code requirements (see SOM § 3202.B.1 for details);
    - If the request for change in Distinct Part Bed Size is to certify all of the facility's beds to the Medicare and/or Medicaid programs (i.e., become fully participating);
    - If the request for change in Distinct Part Bed Size is an increase due to enlargement of the facility through new construction, purchase or lease.

Timing of Request

- Written requests must be submitted to the Indiana State Department of Health no later than forty-five (45) days prior to the first day of the cost reporting year or first day of the cost reporting quarter which will be used as the effective date for the Distinct Part Bed Size change.
- No Distinct Part Bed Size changes will be approved retroactively.

Distinct Part Requirement

- The beds in the certified Distinct Part area must be physically separate from (that is, not commingled with) the beds of the institution in which the Distinct Part is located.

Bed Addition

Bed additions are a request for an increase in the number of facility licensed/certified beds. This transaction requires:

- Plans Approval for addition by the Division of Sanitary Engineering at the Indiana State Department of Health. Description of this process is defined elsewhere in this Administrator's Reference Guide.
- Letter specifically outlining the bed change being requested.
- Facility Floor Plan representing the proposed bed configuration.
- Bed Inventory (State Form 4332) representing the proposed bed configuration.
- Licensure Fee ($10.00 per each additional bed)
- The effective date of change in bed configuration.
- Life Safety Code/Sanitarian/State Fire Code inspections as appropriate

Bed Conversion

Bed conversions are converting an existing bed from comprehensive to residential or vice versa when the facility already has both bed classifications and is already enrolled in the Medicaid and/or Medicare programs. The transaction requires:

- Plans Approval for addition by the Division of Sanitary Engineering at the Indiana State Department of Health. Description of this process is defined elsewhere in this Administrator's Reference Guide.
- Letter specifically outlining the bed change being requested.
- Facility Floor Plan representing the proposed bed configuration.
- Bed Inventory (State Form 4332) representing the proposed bed configuration.
- The effective date of change in bed configuration.
- Life Safety Code/Sanitarian/State Fire Code inspections as appropriate

Bed Decrease

Bed decreases are a request for decreasing, de-licensing, or decertifying the number of beds in a facility. Quite often the terms "Decertifying" and "Decreasing" are misused when bed change requests are submitted from providers.

- Decertifying beds means to make the beds ineligible for reimbursement under either the Medicare or Medicaid programs. In most cases, decertified beds are changed to Non-Certified Comprehensive (NCC) beds or Residential level of care beds. If the decertified beds are not changed to Non-Certified Comprehensive (NCC) or Residential level of care the number of licensed beds will be reduced accordingly.
- De-licensing beds means that you want to decrease the number of licensed beds in the facility.

This transaction requires:

- Letter specifically outlining the bed change being requested.
- Facility Floor Plan representing the proposed bed configuration).
- Bed Inventory (State Form 4332) representing the proposed bed.
- The effective date of change in bed configuration.

Bed Reclassification

Bed reclassifications are a change in the status of existing beds that does not require an increase in bed capacity, decrease in bed classification, or a bed conversion. This transaction requires:

- Letter specifically outlining the bed change being requested.
- Facility Floor Plan representing the proposed bed configuration.
- Bed Inventory (State Form 4332) representing the proposed bed configuration.
- The effective date of change in bed configuration.

Bed Relocation

Bed relocations are a change in location of the licensure and/or certification of a bed from one room within a facility to another. This change type would not result in an increase in bed capacity, decrease in bed classification, bed conversion, or a bed reclassification. This transaction requires:

- Letter specifically outlining the bed change being requested.
- Facility Floor Plan representing the proposed bed configuration.
- Bed Inventory (State Form 4332) representing the proposed bed configuration.
- The effective date of change in bed configuration.

Bed Reserve

The Division of Long Term Care is presently allowing facilities to place beds in "Reserve Status." This means that the beds are simply taken out of the resident room and stored elsewhere, either to provide more living space for residents, or to utilize a room for purposes other than a resident room.

Facilities desiring to place beds in "Reserve Status" should submit a written request to the Division, indicating room number, number of beds to be placed into "Reserve Status," and classification of beds (e.g., Title 18 SNF/19 NF, Title 19 NF, etc.). Facilities desiring to re-activate beds in "Reserve Status" should follow the same procedure before placing the beds back into use. Please keep in mind that placing beds into "Reserve Status" does not affect the total licensed capacity or certified totals. This transaction requires:

- Letter specifically indicating the room number and number of beds to be placed into reserve status and classification of the beds (Residential, NCC, Title 18 SNF, Title 19 NF, and Title 18 SNF/Title 19 NF).
- Facility Floor Plan representing the proposed bed configuration.
- Bed Inventory (State Form 4332) representing the proposed bed configuration.
- The effective date of change in bed configuration.

Distinct Part
Title 18 SNF, Title 19 NF, and Title 18 SNF/Title 19 NF

If the institution or institutional complex is participating as a distinct part SNF and/or NF, for a change to be approved, the requested change in bed size must conform to the requirements to be classified as a distinct part. The Centers for Medicare and Medicaid Services State Operations Manual's Section 2762.B.4 defines Distinct Part:

The term "distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or NF services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes.

An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited.

The distinct part must consist of all beds within the designated area. The distinct part can be a wing, separate building, a floor, a hallway, or one side of a corridor. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However, the distinct part need not be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building or floors or wards that are located throughout several different buildings within the institutional complex. In each case, however, all residents of the distinct part would have to be located in units that are physically separate from those units housing other patients of the institution or institutional complex.

Where an institution or institutional complex owns and operates a distinct part SNF and/or NF, that distinct part SNF and/or NF is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part sub provider, not multiple sub providers, and must be assigned a single provider number.

Plans Approval for New Construction, Additions, or Remodeling

Before Beginning Construction or Remodeling
Prior to the commencement of any construction or remodeling at a facility or beginning construction on a new facility please ensure that any plans and specifications for that project have been approved (if required) by the Indiana State Department of Health, Division of Sanitary Engineering. The general rule is that any new construction, addition, conversion, relocation, renovation, and/or any major change in facility physical plant would require plans approval. To determine if plans are required to be submitted for any project you should contact:

- Program Director-Provider Services 317-233-7794; and
- Division of Sanitary Engineering 317-233-7588.

Also before beginning the construction or remodeling project the facility should contact Program Director-Provider Services (317-233-7794) in order to determine if supplemental application forms or supporting documentation is required for the transaction. New facilities, bed additions, conversions, facility relocations, remodeling project, etc. might have both state and federal requirements in addition to plans approval. Please ensure that all requirements will be met before beginning construction in order to ensure seamless service delivery after completion of project.

After Construction is Complete
Before occupying the area of construction or remodeling:

- Contact the Program Director-Provider Services (317-233-7794) to verify that all application materials and/or requirements have been met; and then
- Submit a "Statement of Substantial Completion - Request for Inspection" (State Form 13025 or a letter to the Program Director-Provider Services. In addition, the facility shall notify the above individual (as appropriate), in writing, when the new construction or remodeled area is ready for the required Sanitarian and Life Safety Code/State Fire Code inspections.

<u>Important:</u>

- **The area cannot be occupied until these inspections have been conducted and released.**

- **For Licensure purposes by the Division of Long Term Care, an "occupancy permit" issued by a city/county agency is not authorization to occupy the newly constructed facility/area.**

- **The Division of Long Term Care will grant permission to occupy only after the Sanitarian and Life Safety Code/State Fire Code Inspection(s) have been conducted and released.**

Commingling Beds
State Licensure Only Beds and Certified Distinct Part

In the past, Nursing Facility (Title 19 NF – Medicaid) beds and Non-Certified Comprehensive (NCC) beds could be co-mingled in a facility providing that the facility could identify the Title 19 NF beds at any given time, and that the facility did not exceed the number of Title 19 NF beds that it was certified for.

The Centers for Medicare and Medicaid Services ("CMS") State Operations Manual ("SOM") Section 2762.5 now includes Nursing Facility (NF Title 19) beds as a "Distinct Part" (please refer to the section concerning "Distinct Part SNF and/or NF"). A Distinct Part, as defined in Section 2762.5 of the CMS SOM, is a certified component of a facility that is separately recognized for the purpose of participation in Medicare or Medicaid.

Based upon the definition of a Distinct Part and the requirements thereof, State Licensure Only beds (Non-Certified Comprehensive (NCC) and Residential Level of Care beds) should not be commingled with Distinct Part (SNF and/or NF) beds.

Certificate of Need (CON)

The Certificate of Need (CON) law expired July 1, 1998. As of that date, there was no longer a "CON Inventory," an inventory of beds held by a Certificate of Need award granted to a facility. Therefore, requests to de-license beds need not include a request to maintain the beds in "CON Inventory."

Residential Beds/Room and Board Assistance Program

Facilities desiring to add Residential Care beds are cautioned that by doing so, these residential beds are not automatically approved for participation in the Room and Board Assistance (RBA) Program.

The residential care beds are licensed by the Indiana State Department of Health (Division of Long Term Care); however, the Room and Board Assistance Program is approved by the Family and Social Services Administration.

Facilities desiring to participate in the Room and Board Assistance (RBA) program should contact:

Family and Social Services Administration
Bureau of Aging and In Home Services
402 West Washington Street
Room W454
Indianapolis, IN 46207
Telephone: 317/232-7017

If you intend to add Residential beds or change your facility's bed classifications to include Residential beds to receive RBA funding, you are required to receive approval from that agency for the RBA program first.

Indiana State Department of Health

TO: Applicants

FROM: Program Director-Provider Services
Division of Long Term Care

Re: **Request for Application for New ICF-MR Group Home**

Please find enclosed the application forms required to be completed and submitted for the opening of a new ICF-MR Group Home:

1. Application for License to Operate a Community Residential Facility (State Form 47952);
2. Assurance of Compliance (Form HHS-690) (2 copies); and
3. Intermediate Care Facility for Persons with Mental Retardation Survey Report (From HCFA-3070G).

In addition to these forms, please submit the following documents:

1. Copy of the letter from the Bureau of Developmental Disabilities' Central Office approving the development of the new home;
2. Copy of the applicant entity's registration with the Indiana Secretary of State;
3. Copy of the floor plan for the new home, to indicate resident bedroom dimensions and square footage; and
4. Letter indicating the date the home will be ready for the Life Safety Code ("LSC") inspection and the Division of Long Term Care Health survey.

Please submit the enclosed forms and requested documentation to the Program Director-Provider Services, Division of Long Term Care 4B, Indiana State Department of Health, 2 N Meridian St, Indianapolis, IN 46204-3006.

In the event that the facility will not be ready for the LSC inspection the date originally specified, immediately contact the LSC Program at 317/233-7711. Failure to communicate requested changes in scheduling could result in delays in opening the home.

After the LSC inspection has been conducted, please ask the surveyor to contact me with verbal approval releasing the inspection, so that verbal permission may be given to occupy the facility. After the facility has moved at least two residents into the home, the facility may submit a written request for the health survey.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding these requirements or the process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A COMMUNITY RESIDENTIAL FACILITY

(Pursuant to Community Residential Facilities Council)
State Form 47952 (R2/12-99)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - IDENTIFYING INFORMATION

Name of applicant *(operator(s) of the facility/home)*			
Street Address			P.O. Box
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*
Name of Executive Director			

SECTON II – TYPE OF ENTITY

For Profit

- ☐ Individual
- ☐ * Partnership
- ☐ ** Corporation
- ☐ *** Limited Liability Company
- ☐ Other *(specify)* _____

_____

_____

Nonprofit

- ☐ Church Related
- ☐ Individual
- ☐ * Partnership
- ☐ ** Corporation
- ☐ *** Limited Liability Company
- ☐ Other *(specify)* _____

_____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION III – RESIDENTIAL FACILITY INFORMATION

A. Address

Street Address		City
County	Zip Code +4	Telephone Number ( )

B. Administrator

Name of Administrator
Qualifications

C. Program Director

Name of Program Director

Qualifications

SECTION IV – TYPE OF PROGRAM

☐ Child Rearing with Specialized Program ☐ Child Rearing ☐ Intensive Training (IT)

☐ Sheltered Living (SL) ☐ Basic Developmental (BD) Number of Residents_____

☐ Small Behavior Management Residence for Children

SECTION V – TYPE OF APPLICATION

Building Type: ☐ House ☐ Apartment

☐ Proposed New Construction

☐ Alteration of Existing House

☐ Other *(Please Explain):*_____

_____

_____

Does applicant own house? ☐ Yes ☐ No

Is applicant buying house? ☐ Yes ☐ No

Is applicant leasing house? ☐ Yes ☐ No

Note: If house is being leased, submit copy of lease.

SECTION VI – COMPLIANCE WITH RULES

Have you read, and do you understand, the Community Residential Facilities Council Rules? ☐ Yes ☐ No
(431 IAC 1.1, 431 IAC 3.1 and 431 IAC 4)

Will you comply with all laws and rules of the Community Residential Facilities Council as they pertain to the operation of licensed residential facilities for the developmentally disabled? ☐ Yes ☐ No

Does this home agree not to discriminate based on race, color creed, or national origin as provided for in operational policies? ☐ Yes ☐ No

SECTION VII – CERTIFICATION OF APPLICATION

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge, and that I will comply with all laws and rules governing the licensing of residential facilities for the developmentally disabled in Indiana.

Name of authorized representative *(typed)*	Title
Signature	Date

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No. W1

9. State/Region code W2	10. State/County code W3	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5

12. Type of Ownership or Control (enter number in box below) W6

☐ 1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other *(specify)* _____

13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? W7

☐ Yes ☐ No

14. If "Yes" to block 13, indicate either W8

A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. .....

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QMRP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify) _____		
N. Total number of Surveyors onsite	W11	
O. Total number of QMRP Surveyors onsite	W12	

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel W23
(483.430(d)(3)) .....

B. Registered Nurse W24
(483.480(d)(3)) .....

C. Licensed Voc./Practical Nurse W25
(483.480(d)(2)) .....

D. Total Personnel (W26) .....
(List the Full Time Equivalent for all employees)

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(check one)* ☐ Yes ☐ No W13
If *"No"*, proceed to item C.

B. If *"Yes,"* indicate name and address of larger organization.

Name

Address

City	State	ZIP Code

Name of CEO

Total Number of Beds W14

Total Number of Clients W15
(including ICF/MR clients directly served)

C. Total Number of ICF/MR Clients W16

D. Is this ICF/MR community-based? *(check one)* ..... ☐ Yes ☐ No W17

E. Total number of ICF/MR beds under this Provider No. W18

F. Total number of discrete living units under this Provider No. W19

G. Age range of clients served ..... *from* W20 *to* W21

H. Total number of off-campus day program sites used by ICF/MR clients W22

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs? W27

B. In how many off-campus day program sites was an observation done by the Surveyor? W28

20. Individual Characteristics *(Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)*

A.

(1) Age

under 22(a) W29

22-45 (b) W30

46-65 (c) W31

66+ (d) W32

[redacted] Total W33

(2) SEX

Male W34

Female W35

[redacted] Total W36

B. DISABILITIES

(1) Mental Retardation

Mild W37

Moderate W38

Severe W39

Profound W40

[redacted] Total W41

(2) Autism W42

(3) Cerebral Palsy W43

(4) Epilepsy

Controlled W44

Uncontrolled W45

[redacted] Total W46

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile W47

Non-Mobile W48

[redacted] Total W49

(2) Speech/Language Impairment W50

(3) Hearing Impairment

Hard of Hearing W51

Deaf W52

[redacted] Total W53

(4) Visual Impairment

Impaired W54

Blind W55

[redacted] Total W56

D. MEDICAL CARE PLAN W57

E. DRUGS TO CONTROL BEHAVIOR W58

F. PHYSICAL RESTRAINTS W59

G. TIME-OUT ROOMS W60

H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI W61

I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS W62

J. NUMBER OF COURT ORDERED ADMISSIONS W63

K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT W64

L. OTHER *(specify)*

(1) W65

(2) W66

(3) W67

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a)	W68
no. of allegations of neglect investigated (b)	W69
[redacted] Total	W70

N. NUMBER OF DEATHS

no. of deaths related to unusual incidents (a)	W71
no. of deaths related to restraints (b)	W72
no. of deaths for any reason (c)	W73
[redacted] Total	W74

Indiana State Department of Health

Division of Long Term Care

CHANGE OF OWNERSHIP APPLICATION
TITLE 19 NF

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for a change of ownership application for Medicaid certified health facilities. For additional information on the rules and regulations involving this action please refer to:
http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, with required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments;
5. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
6. Two (2) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
7. State Form 4332, Bed Inventory (enclosed);
8. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
9. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
10. Copy(s) of new Services Agreements/Contracts between the applicant entity and third parties;
11. Staffing plan to include the number, educational level, and personal health of employees; and
12. Copy of the facility's disaster plan.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

The following is a general outline of the application process:

1. The following documents must be submitted prior to the effective date for the change of ownership in order for the Division of Long Term Care to grant authorization for the new owner to occupy the facility:
   (1) Completed State Form 8200, Application For License To Operate A Health Facility, with required attachments;
   (2) Documentation of the applicant entity's registration with the Indiana Secretary of State;
   (3) Completed State Form 51996, Independent Verification Of Assets And Liabilities, with required attachments;
   (4) Fully executed copy of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal document for the change of ownership, which indicates the effective date for the change of ownership transaction;

NOTE: Provided the Division of Long Term Care has been notified as to the date of the closing or lease signing, the fully executed legal document for the change of ownership transaction may be submitted to the Division via overnight delivery or facsimile immediately after the effective date (but must be received within seven (7) days of the effective date).

2. Upon receipt of these items, and upon the Division Director's satisfaction that the applicant entity meets the requirements of Indiana Code 16-28-2-1 *et seq*., the Director may grant authorization for the applicant entity to operate the facility;
3. The remainder of the application items are due no later than twenty-one (21) days from the date of the authorization to occupy letter;
4. Upon receipt of the completed change of ownership application documentation, the Division of Long Term Care will forward appropriate documents to the State Medicaid Agency for processing;
5. The State Medicaid Agency will forward to the facility a letter acknowledging the change of ownership.

Under normal circumstances, licensure and certification survey for a change of ownership is not required.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Othe**r_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	Number of Beds in Each Category (to be licensed)	2. Certification Designation	Number of Beds in Each Category (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds		**Total Certified Beds**	

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT

(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership

☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit

☐ Individual
☐ * Partnership
☐ ** Corporation
☐ *** Limited Liability Company
☐ Other *(specify)* _____
_____
_____

NonProfit

☐ Church Related
☐ Individual
☐ * Partnership
☐ ** Corporation
☐ *** Limited Liability Company
☐ Other *(specify)* _____
_____

Government

☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

If yes, explain_____

_____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
(*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)

   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.

   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)*

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility		
Street Address		
City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:*_____*)*** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd)	To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B			
Street Address			P.O. Box
City	State	Zip Code + 4	

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $ _____**

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: $_____

Projected Monthly Operating Expenses: $_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	No. Beds
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.

Completed by	Position	Date

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

Date

Signature and Title of Authorized Official

Name of Applicant or Recipient

Street

City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group? F24 Yes ☐ No ☐
Does the facility currently have an organized group of family members of residents? F25 Yes ☐ No ☐
Does the facility conduct experimental research? F26 Yes ☐ No ☐
Is the facility part of a continuing care retirement community (CCRC)? F27 Yes ☐ No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

Form CMS-671 (12/02)

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

Indiana State Department of Health

Division of Long Term Care

CHANGE OF OWNERSHIP APPLICATION
TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

TO: Applicant

FROM: Program Director, Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for a change of ownership application for Medicare and/or Medicaid certified health facilities. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, with required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments (State Form 51996 enclosed);
5. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
6. Three (3) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
7. Three (3) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
8. Documentation of compliance with Civil Rights requirements (forms and instructions enclosed);
9. Completed State Form 4332, Bed Inventory (enclosed);
10. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
11. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
12. Copy(s) of new Services Agreements/Contracts between the applicant entity and third parties;
13. Staffing plan to include the number, educational level, and personal health of employees; and
14. Copy of the facility's disaster plan.

In addition, the facility must contact the Medicare Fiscal Intermediary, AdminaStar Federal (or your CMS approved Fiscal Intermediary), for Form CMS-855A. The facility may reach AdminaStar Federal at 317/841-4540. The completed Form CMS-855A should be forwarded directly to AdminaStar Federal for review and recommendation for approval.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

The following is a general outline of the application process:

1. The following documents must be submitted prior to the effective date for the change of ownership in order for the Division of Long Term Care to grant authorization for the new owner to occupy the facility:
    (1) Completed State Form 8200, Application For License To Operate A Health Facility, with required attachments;
    (2) Documentation of the applicant entity's registration with the Indiana Secretary of State;
    (3) Completed State Form 51996, Independent Verification Of Assets And Liabilities, with required attachments;
    (4) Fully executed copy of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal document for the change of ownership, which indicates the effective date for the change of ownership transaction;

    NOTE: Provided the Division of Long Term Care has been notified as to the date of the closing or lease signing, the fully executed legal document for the change of ownership transaction may be submitted to the Division via overnight delivery or facsimile immediately after the effective date (but must be received within seven (7) days of the effective date).
2. Upon receipt of these items, and upon the Division Director's satisfaction that the applicant entity meets the requirements of Indiana Code 16-28-2-1 *et seq*., the Director may grant authorization for the applicant entity to operate the facility;
3. The remainder of the application items are due no later than twenty-one (21) days from the date of the authorization to operate;
4. Upon receipt of the completed change of ownership application documentation, the Division of Long Term Care will forward appropriate documents to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency for processing;
5. The Fiscal Intermediary will forward to the facility its determination of the CMS-855A *Medicare General Enrollment Application*, and will copy the Division of Long Term Care and CMS;
6. CMS will forward to the facility a letter acknowledging the change of ownership, and will copy the Division of Long Term Care.

Under normal circumstances, a licensure and certification survey for a change of ownership is not required.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Other**_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	*Number of Beds in Each Category* (to be licensed)	**2. Certification Designation**	*Number of Beds in Each Category* (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds		**Total Certified Beds**	

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

If yes, explain_____

_____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
(*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed* **summary of the events and circumstances. Include state, dates and names of facilities)**

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:*_____*)*** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd)	To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B		
Street Address		P.O. Box
City	State	Zip Code + 4

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $** _____

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

Form CMS-1561 (07/01) Previous Version Obsolete

Office for Civil Rights
Medicare Certification
Nondiscrimination Policies and Notices

Please note that documents in PDF format require Adobe's Acrobat Reader.

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Go to 45 CFR Part 80 for the full regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to **§**84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Go to 45 CFR Part 84 for the full regulation.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against

discrimination provided by the Act and these regulations.

Go to 45 CFR Part 91 for the full regulation.

Policy Examples

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Medicare Certification
Communication with Persons Who Are Limited English Proficient

Please note that documents in PDF format require Adobe's Acrobat Reader.

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Go to 45 CFR Part 80 for the full regulation.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

"I Speak" Language Identification Flashcard (PDF) From the Department of Commerce, Bureau of the Census, the "I Speak" Language Identification Flashcard is written in 38 languages and can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services- http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.
- Nonvital written materials could include:
- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.

- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Medicare Certification
Auxiliary Aids and Services for Persons With Disabilities

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees "shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question." (2) Pursuant to the Department's discretion, recipients with fewer than fifteen employees may be required "to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services." (3) "Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision."

Go to 45 CFR Part 84 for the full regulation.

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent

2. Authorization to Disclose Medical Information

3. Personal Valuables

4. Financial Agreement

5. Assignment of Insurance Benefits

6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice Document:

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings

ADA Document Portal

A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic.

Medicare Certification
Requirements for Facilities with 15 or More Employees

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Go to 45 CFR Part 84 for the full regulation.

Policy Example

The following procedure incorporates appropriate minimum due process standards and may serve as a model or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

SECTION 504 GRIEVANCE PROCEDURE

It is the policy of (**insert name of facility/agency**) not to discriminate on the basis of disability. (**Insert name of facility/agency**) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the office of (**insert name, title, tel. no. of Section 504 Coordinator**), who has been designated to coordinate the efforts of (**insert name of facility/agency**) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (**insert name of facility/agency**) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (**insert time frame**) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (**insert name of facility/agency**) relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (**Administrator/Chief Executive Officer/Board of Directors/etc.**) within 15 days of receiving the Section 504 Coordinator's decision.
- The (**Administrator/Chief Executive Officer/Board of Directors/etc.**) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(**Insert name of facility/agency**) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Medicare Certification
Age Discrimination Act Requirements

Please note that documents in PDF format require Adobe's Acrobat Reader.

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance, directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.

(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

For the full regulation, go to 45 CFR Part 91.

Medicare Certification Civil Rights Information Request Form

Please return the completed, signed Civil Rights Information Request form and the required attachments with your other Medicare Provider Application Materials.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE FACILITY:

a. **CMS Medicare Provider Number:**_____

b. **Name and Address of Facility:** _____

_____

_____

c. **Administrator's Name** _____

d. **Contact Person** _____
(If different from Administrator)

e. **Telephone** _____ **TDD** _____

f. **E-mail** _____ **FAX** _____

g. **Type of Facility** _____
(e.g., Home Health Agency, Hospital, Skilled Nursing Facility, etc.)

h. **Number of employees:** _____

i. **Corporate Affiliation** _____ (if the facility is now or will be owned and operated by a corporate chain or multi-site business entity, identify the entity.)

j. **Reason for Application** _____
(Initial Medicare Certification, change of ownership, etc.)

PLEASE RETURN THE FOLLOWING MATERIALS WITH THIS FORM.

To ensure accuracy, please consult the technical assistance materials** (www.hhs.gov/ocr/crclearance.html) **in developing your responses.

√	No.	REQUIRED ATTACHMENTS
	1.	Two original signed copies of the form HHS-690, Assurance of Compliance (www.hhs.gov/ocr/ps690.pdf). *A copy should be kept by your facility.*
Nondiscrimination Policies and Notices *Please see Nondiscrimination Policies and Notices (www.hhs.gov/ocr/nondiscriminpol.html) for the regulations and technical assistance.*		
	2.	A copy of your written notice(s) of nondiscrimination, *that provide for admission and services without regard to race, color, national origin, disability, or age, as required by Federal law. Generally, an EEO policy is not sufficient to address admission and services.*
	3.	A description of the methods used by your facility to disseminate your nondiscrimination notice(s) or policy. *If published, also identify the extent to which and to whom such policies/notices are published (e.g., general public, employees, patients/residents, community organizations, and referral sources) consistent with requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.*
	4.	Copies of brochures or newspaper articles. *If publication is one of the methods used to disseminate the policies/notices, these copies must be attached.*
	5.	A copy of facility admissions policy or policies.
Communication with Persons Who Are Limited English Proficient (LEP) *Please see Communication with Persons Who Are Limited English Proficient (LEP) (www.hhs.gov/ocr/commune.html) for technical assistance. For information on the obligation to take reasonable steps to provide meaningful access to LEP persons, including guidance on what constitutes vital written materials, and HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at www.hhs.gov/ocr/lep . This guidance is also available at http://www.lep.gov/ , along with other helpful information pertaining to language services for LEP persons.*		
	6.	*A description (or copy) of procedures used by your facility to effectively communicate with persons who have limited English proficiency, including:* 1. How you identify individuals who are LEP and in need of language assistance. 2. How language assistance measures are provided (for both oral and written communication) to persons who are LEP, consistent with Title VI requirements. *3.* How LEP persons are informed that language assistance services are available.
	7.	A list of all vital written materials provided by your facility, and the languages for which they are available. *Examples of such materials may include consent and complaint forms; intake forms with the potential for important consequences; written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services; applications to participate in a recipient's program or activity or to receive recipient benefits or service; and notices advising LEP persons of free language assistance.*

√	No.	REQUIRED ATTACHMENTS
Auxiliary Aids and Services for Persons with Disabilities *Please see Auxiliary Aids and Services for Persons with Disabilities (www.hhs.gov/ocr/auxaids.html) for technical assistance.*		
	8.	A description (or copy) of the procedures used to communicate effectively with individuals who are deaf, hearing impaired, blind, visually impaired or who have impaired sensory, manual or speaking skills, including: 1. How you identify such persons and how you determine whether interpreters or other assistive services are needed. 2. Methods of providing interpreter and other services during all hours of operation as

√	No.	REQUIRED ATTACHMENTS
		necessary for effective communication with such persons. 3. A list of available auxiliary aids and services, and how persons are informed that interpreters or other assistive services are available. 4. The procedures used to communicate with deaf or hearing impaired persons over the telephone, including TTY/TDD or access to your State Relay System, and the telephone number of your TTY/TDD or your State Relay System.
	9.	Procedures used by your facility to disseminate information to patients/residents and potential patients/residents about the existence and location of services and facilities that are accessible to persons with disabilities.
Requirements for Facilities with 15 or More Employees *Please see Requirements for Facilities with 15 or More Employees (www.hhs.gov/ocr/reqfacilities.html) for technical assistance.*		
	10.	For recipients with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
	11.	For recipients with 15 or more employees: A copy or description of your facility's procedure for handling disability discrimination grievances.
Age Discrimination Act Requirements *Please see Age Discrimination Act Requirements (www.hhs.gov/ocr/agediscrim.html) for technical assistance, and for information on permitted exceptions.*		
	12.	A description or copy of any policy (ies) or practice(s) restricting or limiting admissions or services provided by your facility on the basis of age. *If such a policy or practice exists, please submit an explanation of any exception/exemption that may apply. In certain narrowly defined circumstances, age restrictions are permitted.*

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided. Failure to provide the information/data requested may delay your facility's certification for funding.

Certification: **I certify that the information provided to the Office for Civil Rights is true and correct to the best of my knowledge.**

Signature of Authorized Official: _____

Title of Authorized Official: _____

Date: _____

BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed

Completed by	Position	Date

Indiana State Department of Health

Division of Long Term Care

CHANGE OF OWNERSHIP APPLICATION
RESIDENTIAL

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for a change of ownership application for Residential facilities. For additional information on the rules and regulations involving this action please refer to:
http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, with required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets and Liabilities, with required documentation (State Form 51996 enclosed);
5. Completed State Form 4332, Bed Inventory (enclosed);
6. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
7. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
8. A staffing plan that should include the number, educational level and personal health of employees;
9. Agreements/Contracts between the applicant entity with various providers of services for residents within the facility:
   a. Dietician;
   b. Emergency Shelter;
   c. Emergency Water Supply;
   d. Hospital Transfer Agreement(s) (if applicable, but not required);
   e. Pharmacy Services; and
   f. Pharmacy Consultant Services (if applicable).

   NOTE: Facilities with contracts for services which require a licensed and/or certified professional should include copies of the licenses and/or certification for the individuals who will be providing the services.

The following is a general outline of the application process:

1. The following documents must be submitted prior to the effective date for the change of ownership in order for the Division of Long Term Care to grant authorization for the new owner to occupy the facility:

    a. Completed State Form 8200, Application For License To Operate A Health Facility, with required attachments;

    b. Documentation of the applicant entity's registration with the Indiana Secretary of State;

    c. State Form 51996, Independent Verification Of Assets And Liabilities, with required attachments;

    d. Fully executed copy of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal document for the change of ownership, which indicates the effective date for the change of ownership transaction;

    NOTE: Provided the Division of Long Term Care has been notified as to the date of the closing or lease signing, the fully executed legal document for the change of ownership transaction may be submitted to the Division via overnight delivery or facsimile immediately after the effective date (but must be received within seven (7) days of the effective date)

2. Upon receipt of these items, and upon the Division Director's satisfaction that the applicant entity meets the requirements of Indiana Code 16-28-2-1 *et seq*., the Director may grant authorization for the applicant entity to occupy the facility. The applicant entity has twenty-one (21) days after the authorization to operate the facility has been granted to submit the remainder of the application materials.

Under normal circumstances, a licensure survey for a change of ownership is not required.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Othe**r_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	Number of Beds in Each Category (to be licensed)	2. Certification Designation	Number of Beds in Each Category (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds	_____	**Total Certified Beds**	_____

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

   If yes, explain_____

   _____

   Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
   (*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)*

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

_____

_____

_____

_____

_____

_____

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:_____*)** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd)	To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B			
Street Address			P.O. Box
City	State	Zip Code + 4	

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $ _____**

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

BED INVENTORY
State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed

Completed by	Position	Date

Complaints

Complaint Hotline
1-800-246-8909

Program
A complaint is an allegation of noncompliance with Federal and/or State requirements. The mission of the complaints process is to protect Medicare/Medicaid beneficiaries from abuse, neglect, exploitation, inadequate care or supervision. The Federal complaint/incident process is a system that will assist in promoting and protecting the health, safety, and welfare of residents, patients, and clients receiving health care services.

Survey Requirement due to Complaint
Section 42 CFR 488.332 provides the Federal regulatory basis for the investigation of complaints about nursing homes. The survey agency must review all complaint allegations and conduct a standard or an abbreviated standard survey to investigate complaints of violations of requirements if its review of the allegation concludes that:

- A deficiency in one or more of the requirements may have occurred; and
- Only a survey can determine whether a deficiency or deficiencies exist.

5075.9 - Maximum Time Frames Related to the Federal Onsite Investigation of Complaints/Incidents

(Rev. 18, Issued: 03-17-06; Effective/Implementation Dates: 03-17-06)

	Intake Prioritization			
Provider Type	*Immediate Jeopardy (IJ)*	*Non-IJ High*	*Non-IJ Medium*	*Non-IJ Low*
Nursing homes	SA must initiate an onsite survey within 2 working days of receipt.	SA must initiate an onsite survey within 10 working days of prioritization.	No timeframe specified, but an onsite survey should be scheduled.	SA should investigate during the next onsite survey.
Non-deemed providers/suppliers, other than nursing homes	SA must initiate an onsite survey within 2 working days of receipt.	N/A	SA must initiate an onsite survey within 45 calendar days of prioritization	SA should investigate during the next onsite survey.
Deemed providers/suppliers	SA must initiate an onsite survey within 2 working days of receipt of RO authorization	N/A	SA must initiate an onsite survey within 45 calendar days of receipt of RO authorization.	SA should investigate during the next onsite survey.
CLIA, non-exempt, non-accredited	SA investigates within 2 working days of receipt	N/A	N/A	N/A
CLIA, exempt	SA notifies RO within 10 calendar days	N/A	N/A	N/A
CLIA, accredited	SA submits information to RO within 2 calendar days	N/A	N/A	N/A
EMTALA	SA must complete investigation within 5 days of receipt of RO authorization.	N/A	N/A	N/A
Death related to restraint/seclusion used for behavior management-Hospitals	SA must complete an onsite investigation within 5 working days of telephone authorization from the RO.	N/A	N/A	N/A
Fires resulting in serious injury or death	SA must initiate an onsite survey within 2 working days of receipt.	N/A	N/A	N/A

Indiana State Department of Health

Division of Long Term Care

APPLICATION FOR MEDICARE PARTICIPATION
CONVERSION FROM TITLE 19 NF TO TITLE 18 SNF/ TITLE 19 NF

TO: Applicant

FROM: Enforcement Manager
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in the Medicare Program.

An application should include the following forms and/or documentation:

1. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
2. Three (3) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
3. Three (3) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
4. Documentation of compliance with Civil Rights requirements (forms and instructions enclosed);
5. State Form 4332, Bed Inventory, to reflect the proposed number and classification of beds after acceptance into the Medicare Program (enclosed);
6. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room, to reflect the configuration after acceptance into the Medicare Program; and
7. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s).

In addition, the facility must contact the Medicare Fiscal Intermediary, AdminaStar Federal (or the designated CMS approved Fiscal Intermediary), for Form CMS-855A. The facility may reach AdminaStar Federal at 317/841-4540. The completed Form CMS-855A should be forwarded directly to AdminaStar Federal for review and recommendation for approval.

Once the Division of Long Term Care ("Division") has received and approved the completed application documents, and has received a copy of the approval of the Form CMS-855A *Medicare General Enrollment* application, the Division will process the application, along with a copy of the facility's most recent certification survey for Medicaid (if the survey is no more than six (6) months old) to the Centers for Medicare and Medicaid Services ("CMS") for approval. If CMS accepts this survey as demonstration of the facility's compliance with federal regulations, the effective participation will be the date that the CMS-855A application was approved. CMS may require another certification survey prior to admittance to the Medicare program. If this is the case, CMS will notify the facility in writing. The program effective date would then be the exit date of the survey if no deficiencies were found at the time of the survey, or the date that an acceptable plan of correction was received if deficiencies were found at the time of the survey.

Please do not hesitate to contact me at 317/233-7613 should you have questions regarding the application process.

Enclosures

Revised March 2005

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

	Tag Number	A			B					C					D				
		Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

Office for Civil Rights

Medicare Certification

Nondiscrimination Policies and Notices

Please note that documents in PDF format require Adobe's Acrobat Reader.

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Go to 45 CFR Part 80 for the full regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to §84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Go to 45 CFR Part 84 for the full regulation.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

Go to 45 CFR Part 91 for the full regulation.

Policy Examples

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Medicare Certification

Communication with Persons Who Are Limited English Proficient

Please note that documents in PDF format require Adobe's Acrobat Reader.

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of

individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Go to 45 CFR Part 80 for the full regulation.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

"I Speak" Language Identification Flashcard (PDF) From the Department of Commerce, Bureau of the Census, the "I Speak" Language Identification Flashcard is written in 38 languages and can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services- http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.

Nonvital written materials could include:

- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.
- For a non-governmental recipient, government documents and forms.

- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Medicare Certification

Auxiliary Aids and Services for Persons With Disabilities

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any

aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees “shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question.” (2) Pursuant to the Department’s discretion, recipients with fewer than fifteen employees may be required “to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services.” (3) “Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision.”

Go to 45 CFR Part 84 for the full regulation.

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent

2. Authorization to Disclose Medical Information

3. Personal Valuables

4. Financial Agreement

5. Assignment of Insurance Benefits

6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice Document:

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings

ADA Document Portal
A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic.

Medicare Certification

Requirements for Facilities with 15 or More Employees

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Go to 45 CFR Part 84 for the full regulation.

Policy Example

The following procedure incorporates appropriate minimum due process standards and may serve as a model or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

SECTION 504 GRIEVANCE PROCEDURE

It is the policy of (**insert name of facility/agency**) not to discriminate on the basis of disability. (**Insert name of facility/agency**) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the office of (**insert name, title, tel. no. of Section 504 Coordinator**), who has been designated to coordinate the efforts of (**insert name of facility/agency**) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (**insert name**

of facility/agency) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (**insert time frame**) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (**insert name of facility/agency**) relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (**Administrator/Chief Executive Officer/Board of Directors/etc.**) within 15 days of receiving the Section 504 Coordinator's decision.
- The (**Administrator/Chief Executive Officer/Board of Directors/etc.**) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(**Insert name of facility/agency**) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Medicare Certification

Age Discrimination Act Requirements

Please note that documents in PDF format require Adobe's Acrobat Reader.

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance,

directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.
(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

For the full regulation, go to 45 CFR Part 91.

Medicare Certification Civil Rights Information Request Form

Please return the completed, signed Civil Rights Information Request form and the required attachments with your other Medicare Provider Application Materials.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE FACILITY:

a. **CMS Medicare Provider Number:**_____

b. **Name and Address of Facility:** _____

_____

_____

c. **Administrator's Name** _____

d. **Contact Person** _____
(If different from Administrator)

e. **Telephone** _____ **TDD** _____

f. **E-mail** _____ **FAX** _____

g. **Type of Facility** _____
(e.g., Home Health Agency, Hospital, Skilled Nursing Facility, etc.)

h. **Number of employees:** _____

i. **Corporate Affiliation** _____ (if the facility is now or will be owned and operated by a corporate chain or multi-site business entity, identify the entity.)

j. **Reason for Application** _____
(Initial Medicare Certification, change of ownership, etc.)

PLEASE RETURN THE FOLLOWING MATERIALS WITH THIS FORM.

To ensure accuracy, please consult the technical assistance materials (www.hhs.gov/ocr/crclearance.html) **in developing your responses.**

√	No.	REQUIRED ATTACHMENTS
	1.	Two original signed copies of the form HHS-690, Assurance of Compliance (www.hhs.gov/ocr/ps690.pdf). *A copy should be kept by your facility.*
Nondiscrimination Policies and Notices *Please see Nondiscrimination Policies and Notices (www.hhs.gov/ocr/nondiscriminpol.html) for the regulations and technical assistance.*		
	2.	A copy of your written notice(s) of nondiscrimination, *that provide for admission and services without regard to race, color, national origin, disability, or age, as required by Federal law. Generally, an EEO policy is not sufficient to address admission and services.*
	3.	A description of the methods used by your facility to disseminate your nondiscrimination notice(s) or policy. *If published, also identify the extent to which and to whom such policies/notices are published (e.g., general public, employees, patients/residents, community organizations, and referral sources) consistent with requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.*
	4.	Copies of brochures or newspaper articles. *If publication is one of the methods used to disseminate the policies/notices, these copies must be attached.*
	5.	A copy of facility admissions policy or policies.
Communication with Persons Who Are Limited English Proficient (LEP) *Please see Communication with Persons Who Are Limited English Proficient (LEP) (www.hhs.gov/ocr/commune.html) for technical assistance. For information on the obligation to take reasonable steps to provide meaningful access to LEP persons, including guidance on what constitutes vital written materials, and HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at www.hhs.gov/ocr/lep . This guidance is also available at http://www.lep.gov/ , along with other helpful information pertaining to language services for LEP persons.*		
	6.	A description (or copy) of procedures used by your facility to effectively communicate with persons who have limited English proficiency, including: 1. *How you identify individuals who are LEP and in need of language assistance.* 2. *How language assistance measures are provided (for both oral and written communication) to persons who are LEP, consistent with Title VI requirements.* 3. *How LEP persons are informed that language assistance services are available.*
	7.	A list of all vital written materials provided by your facility, and the languages for which they are available. *Examples of such materials may include consent and complaint forms; intake forms with the potential for important consequences; written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services; applications to participate in a recipient's program or activity or to receive recipient benefits or service; and notices advising LEP persons of free language assistance.*

√	No.	REQUIRED ATTACHMENTS
Auxiliary Aids and Services for Persons with Disabilities *Please see Auxiliary Aids and Services for Persons with Disabilities (www.hhs.gov/ocr/auxaids.html) for technical assistance.*		
	8.	A description (or copy) of the procedures used to communicate effectively with individuals who are deaf, hearing impaired, blind, visually impaired or who have impaired sensory, manual or speaking skills, including: 1. *How you identify such persons and how you determine whether interpreters or other assistive services are needed.* 2. *Methods of providing interpreter and other services during all hours of operation as necessary for effective communication with such persons.*

√	No.	REQUIRED ATTACHMENTS
		3. *A list of available auxiliary aids and services, and how persons are informed that interpreters or other assistive services are available.* 4. *The procedures used to communicate with deaf or hearing impaired persons over the telephone, including TTY/TDD or access to your State Relay System, and the telephone number of your TTY/TDD or your State Relay System.*
	9.	Procedures used by your facility to disseminate information to patients/residents and potential patients/residents about the existence and location of services and facilities that are accessible to persons with disabilities.
Requirements for Facilities with 15 or More Employees *Please see Requirements for Facilities with 15 or More Employees (www.hhs.gov/ocr/reqfacilities.html) for technical assistance.*		
	10.	For recipients with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
	11.	For recipients with 15 or more employees: A copy or description of your facility's procedure for handling disability discrimination grievances.
Age Discrimination Act Requirements *Please see Age Discrimination Act Requirements (www.hhs.gov/ocr/agediscrim.html) for technical assistance, and for information on permitted exceptions.*		
	12.	A description or copy of any policy (ies) or practice(s) restricting or limiting admissions or services provided by your facility on the basis of age. *If such a policy or practice exists, please submit an explanation of any exception/exemption that may apply. In certain narrowly defined circumstances, age restrictions are permitted.*

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided. Failure to provide the information/data requested may delay your facility's certification for funding. *Certification*: I certify that the information provided to the Office for Civil Rights is true and correct to the best of my knowledge.

Signature of Authorized Official: _____

Title of Authorized Official: _____

Date: _____

BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	No. Beds
	2
	2
8	2
9	3
10	2
11	2
12	
20	

Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.

Completed by	Position	Date

Indiana State Department of Health

Division of Long Term Care

APPLICATION FOR MEDICARE (TITLE 18 SNF) AND/OR MEDICARE/MEDICAID (TITLE 18 SNF/ TITLE 19 NF) PARTICIPATION
CONVERSION FROM STATE LICENSED ONLY

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in the Medicare and/or Medicaid Programs. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

If the application is for Medicare certification only (Title 18 SNF), or for Medicare/Medicaid (Title 18 SNF/ Title 19 NF), it should include the following forms and/or documentation:

1. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
2. Form HHS-690, Assurance of Compliance (3 signed originals, forms enclosed);
3. Form CMS-1561, Health Insurance Benefit Agreement (3 signed originals, forms enclosed);
4. Civil Rights compliance documentation (forms and instructions enclosed);
5. State Form 4332, Bed Inventory, to reflect the proposed number and classification of beds after acceptance into the Medicare and/or Medicaid Programs (enclosed);
6. Proposed staffing plan based upon 20%, 50% and 100% occupancy for the number of beds to be certified (to include all RN, LPN, QMA and CNA hours);
7. List of Key Personnel, to include name and position title or function;
8. Proposed nurse staffing schedule (by position) for a two (2) week period, indicating nursing hours per resident per day;
9. Copy of the facility's Quality Assessment and Assurance Committee Policy;
10. Copy of all Patient Transfer Agreements with hospitals;

    NOTE: Each contract, with the exception of the Hospital Patient Transfer Agreement, should include language to indicate that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and ensures the timeliness of services provided. (See 42 CFR 483.75(h)(2). Please highlight the section in the service agreement that includes this language when submitting the agreements with the application.

    NOTE: Facilities with contracts for services which require a licensed and/or certified professional should include copies of the licenses and/or certification for the individuals who will be providing the services.

11. Nursing Facility Service/Contract Agreements for the applicant entity:

a. Audiology;
b. Beauty and/or Barber Services;
c. Dentistry Services;
d. Dialysis Services (if applicable);
e. Dietician;
f. Emergency Shelter;
g. Emergency Water Supply;
h. Hospice Services (if applicable);
i. Hospital Transfer Agreement (s);
j. IV Therapy (if applicable);
k. Laboratory Services;
l. Laundry and/or Housekeeping Services (if applicable);
m. Medical Director;
n. Mental Health Services;
o. Nursing Pool Services (if applicable);
p. Occupational Therapy;
q. Optometry;
r. Oxygen Services (if applicable);
s. Pharmacy Services;
t. Physical Therapy;
u. Podiatry Services;
v. Respiratory Therapy;
w. Speech Therapy;
x. X-ray Services; and

12. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room, to reflect the configuration after acceptance into the Medicare Program.

In addition, the must contact the Medicare Fiscal Intermediary, AdminaStar Federal (or designated CMS approved Fiscal Intermediary), for Form CMS-855A, the Medicare General Enrollment Provider/Supplier Application. The facility may reach AdminaStar Federal at 317/841-4540. The completed Form CMS-855A should be forwarded directly to AdminaStar Federal for review and recommendation for approval.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

Prior to the Division of Long Term Care granting authorization for the facility to admit comprehensive care residents, the following must occur:

1. The Indiana State Department of Health, Division of Sanitary Engineering must approve the plans and specifications for the facility to ensure that the physical structure meets the requirements for comprehensive beds;
2. If any modifications to the building are to be made, the project architect must submit to the Division of Long Term Care a Certificate of Substantial Completion to verify that any and all modifications are complete; and
3. The facility must pass Life Safety Code and Sanitarian inspections.

- Once the Fiscal Intermediary has approved the CMS-855A application, the facility may submit to the Division of Long Term Care a written request for the Life Safety Code and Sanitarian inspections.
- Once these inspections have been completed and released, the Division of Long Term Care will forward to the facility an authorization to admit comprehensive care residents.
- Once the facility has received this, and is ready for the initial certification survey, the facility may submit a written request for initial certification survey, noting that at least two (2) residents are receiving comprehensive level care. *Every effort will be made to schedule the initial certification survey to occur no later than twenty-one (21) calendar days after the date specified in the letter indicating that the facility will be ready for survey.*

The facility must be in substantial compliance with federal requirements to enter the Medicare and/or Medicaid programs. Federal findings, if cited, must not be above a severity level of "C". If the facility is found to be in substantial compliance at the time of survey, the effective date of admission to the program will be the date of exit for the survey. However, if the facility has findings at a severity level of "D" or higher, admission to Medicaid (if applicable) will be denied, and the recommendation for denial for admission to the Medicare program will be made to CMS.

CMS and/or the State Medicaid Agency will notify you in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

Please do not hesitate to contact me at 317/233-7794 with any questions you may have regarding this process.

Enclosures

Revised March 2005

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F2 ☐☐ ☐☐ ☐☐ (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F4 ☐☐ ☐☐ ☐☐ (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ (MM DD YY)

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F29_____

Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31_____

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

	Tag Number	A			B					C					D				
		Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

Office for Civil Rights

Medicare Certification

Nondiscrimination Policies and Notices

Please note that documents in PDF format require Adobe's Acrobat Reader.

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Go to 45 CFR Part 80 for the full regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to §84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Go to 45 CFR Part 84 for the full regulation.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

Go to 45 CFR Part 91 for the full regulation.

Policy Examples

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Medicare Certification

Communication with Persons Who Are Limited English Proficient

Please note that documents in PDF format require Adobe's Acrobat Reader.

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of

individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Go to 45 CFR Part 80 for the full regulation.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

"I Speak" Language Identification Flashcard (PDF) From the Department of Commerce, Bureau of the Census, the "I Speak" Language Identification Flashcard is written in 38 languages and can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services- http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.

Nonvital written materials could include:

- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.
- For a non-governmental recipient, government documents and forms.

- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Medicare Certification

Auxiliary Aids and Services for Persons With Disabilities

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing

any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees “shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question.” (2) Pursuant to the Department’s discretion, recipients with fewer than fifteen employees may be required “to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services.” (3) “Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision.”

Go to 45 CFR Part 84 for the full regulation.

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent

2. Authorization to Disclose Medical Information

3. Personal Valuables

4. Financial Agreement

5. Assignment of Insurance Benefits

6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice Document:

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings

ADA Document Portal
A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic.

Medicare Certification

Requirements for Facilities with 15 or More Employees

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Go to 45 CFR Part 84 for the full regulation.

Policy Example

The following procedure incorporates appropriate minimum due process standards and may serve as a model or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

SECTION 504 GRIEVANCE PROCEDURE

It is the policy of (**insert name of facility/agency**) not to discriminate on the basis of disability. (**Insert name of facility/agency**) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the office of (**insert name, title, tel. no. of Section 504 Coordinator**), who has been designated to coordinate the efforts of (**insert name of facility/agency**) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of

disability may file a grievance under this procedure. It is against the law for (**insert name of facility/agency**) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (**insert time frame**) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (**insert name of facility/agency**) relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (**Administrator/Chief Executive Officer/Board of Directors/etc.**) within 15 days of receiving the Section 504 Coordinator's decision.
- The (**Administrator/Chief Executive Officer/Board of Directors/etc.**) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(**Insert name of facility/agency**) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Medicare Certification

Age Discrimination Act Requirements

Please note that documents in PDF format require Adobe's Acrobat Reader.

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance,

directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.
(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

For the full regulation, go to 45 CFR Part 91.

Medicare Certification Civil Rights Information Request Form

Please return the completed, signed Civil Rights Information Request form and the required attachments with your other Medicare Provider Application Materials.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE FACILITY:

a. **CMS Medicare Provider Number:**_____

b. **Name and Address of Facility:** _____

_____

_____

c. **Administrator's Name** _____

d. **Contact Person** _____
(If different from Administrator)

e. **Telephone** _____ **TDD** _____

f. **E-mail** _____ **FAX** _____

g. **Type of Facility** _____
(e.g., Home Health Agency, Hospital, Skilled Nursing Facility, etc.)

h. **Number of employees:** _____

i. **Corporate Affiliation** _____ (if the facility is now or will be owned and operated by a corporate chain or multi-site business entity, identify the entity.)

j. **Reason for Application** _____
(Initial Medicare Certification, change of ownership, etc.)

PLEASE RETURN THE FOLLOWING MATERIALS WITH THIS FORM.
To ensure accuracy, please consult the technical assistance materials** (www.hhs.gov/ocr/crclearance.html) **in developing your responses.

√	No.	REQUIRED ATTACHMENTS
	1.	Two original signed copies of the form HHS-690, Assurance of Compliance (www.hhs.gov/ocr/ps690.pdf). *A copy should be kept by your facility.*
Nondiscrimination Policies and Notices *Please see Nondiscrimination Policies and Notices (www.hhs.gov/ocr/nondiscriminpol.html) for the regulations and technical assistance.*		
	2.	A copy of your written notice(s) of nondiscrimination, *that provide for admission and services without regard to race, color, national origin, disability, or age, as required by Federal law. Generally, an EEO policy is not sufficient to address admission and services.*
	3.	A description of the methods used by your facility to disseminate your nondiscrimination notice(s) or policy. *If published, also identify the extent to which and to whom such policies/notices are published (e.g., general public, employees, patients/residents, community organizations, and referral sources) consistent with requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.*
	4.	Copies of brochures or newspaper articles. *If publication is one of the methods used to disseminate the policies/notices, these copies must be attached.*
	5.	A copy of facility admissions policy or policies.
Communication with Persons Who Are Limited English Proficient (LEP) *Please see Communication with Persons Who Are Limited English Proficient (LEP) (www.hhs.gov/ocr/commune.html) for technical assistance. For information on the obligation to take reasonable steps to provide meaningful access to LEP persons, including guidance on what constitutes vital written materials, and HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at www.hhs.gov/ocr/lep . This guidance is also available at http://www.lep.gov/ , along with other helpful information pertaining to language services for LEP persons.*		
	6.	*A description (or copy) of procedures used by your facility to effectively communicate with persons who have limited English proficiency, including:* 1. How you identify individuals who are LEP and in need of language assistance. 2. How language assistance measures are provided (for both oral and written communication) to persons who are LEP, consistent with Title VI requirements. 3. How LEP persons are informed that language assistance services are available.
	7.	A list of all vital written materials provided by your facility, and the languages for which they are available. *Examples of such materials may include consent and complaint forms; intake forms with the potential for important consequences; written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services; applications to participate in a recipient's program or activity or to receive recipient benefits or service; and notices advising LEP persons of free language assistance.*

√	No.	REQUIRED ATTACHMENTS
Auxiliary Aids and Services for Persons with Disabilities *Please see Auxiliary Aids and Services for Persons with Disabilities (www.hhs.gov/ocr/auxaids.html) for technical assistance.*		
	8.	A description (or copy) of the procedures used to communicate effectively with individuals who are deaf, hearing impaired, blind, visually impaired or who have impaired sensory, manual or speaking skills, including: 1. How you identify such persons and how you determine whether interpreters or other assistive services are needed. 2. Methods of providing interpreter and other services during all hours of operation as necessary for effective communication with such persons. 3. A list of available auxiliary aids and services, and how persons are informed that interpreters or other assistive services are available.

√	No.	REQUIRED ATTACHMENTS
		4. The procedures used to communicate with deaf or hearing impaired persons over the telephone, including TTY/TDD or access to your State Relay System, and the telephone number of your TTY/TDD or your State Relay System.
	9.	Procedures used by your facility to disseminate information to patients/residents and potential patients/residents about the existence and location of services and facilities that are accessible to persons with disabilities.
Requirements for Facilities with 15 or More Employees *Please see Requirements for Facilities with 15 or More Employees (www.hhs.gov/ocr/reqfacilities.html) for technical assistance.*		
	10.	For recipients with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
	11.	For recipients with 15 or more employees: A copy or description of your facility's procedure for handling disability discrimination grievances.
Age Discrimination Act Requirements *Please see Age Discrimination Act Requirements (www.hhs.gov/ocr/agediscrim.html) for technical assistance, and for information on permitted exceptions.*		
	12.	A description or copy of any policy (ies) or practice(s) restricting or limiting admissions or services provided by your facility on the basis of age. *If such a policy or practice exists, please submit an explanation of any exception/exemption that may apply. In certain narrowly defined circumstances, age restrictions are permitted.*

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided. Failure to provide the information/data requested may delay your facility's certification for funding.

Certification: **I certify that the information provided to the Office for Civil Rights is true and correct to the best of my knowledge.**

Signature of Authorized Official: _____

Title of Authorized Official: _____

Date: _____

BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds

Completed by	Position	Date

Indiana State Department of Health

Division of Long Term Care

APPLICATION FOR CONVERSION FROM RESIDENTIAL CARE TO NON-CERTIFIED COMPREHENSIVE CARE FACILITY

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for conversion from residential level care to non-certified comprehensive level care. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

Please submit the following forms and documentation:

1. State Form 4332, Bed Inventory (enclosed) to reflect the configuration after the conversion.
2. Copy of the facility's floor plan on 8 ½" x 11" paper, to include room numbers and number of beds per room, to reflect the configuration after the conversion;
3. Proposed staffing plan based upon 20%, 50% and 100% occupancy for the number of beds to be converted (to include all RN, LPN, QMA and CNA hours);
4. List of Key Personnel, to include name and position title or function;
5. Proposed nurse staffing schedule (by position) for a two (2) week period, indicating nursing hours per resident per day;
6. Copy of all Patient Transfer Agreements with hospitals; and
7. Copies of all contracts/service agreements between the facility and third parties for services provided to residents.

Prior to the Division of Long Term Care granting authorization for the facility to admit comprehensive care residents, the following must occur:

1. The Indiana State Department of Health, Division of Sanitary Engineering must approve the plans and specifications for the facility to ensure that the physical structure meets the requirements for comprehensive beds (please contact Dennis Ehlers at 317/233-7588 for instructions);
2. If any modifications to the building are to be made, the project architect must submit to the Division of Long Term Care a Certificate of Substantial Completion to verify that any and all modifications are complete; and
3. The facility must pass Life Safety Code and Sanitarian inspections.

- Once the Division of Sanitary Engineering has approved the plans and specifications for the physical plant, the facility may submit a written request for the Life Safety Code and Sanitarian inspections.

- Once these inspections have been completed and released, the Division of Long Term Care forward to the facility an authorization to admit comprehensive care residents.
- Once the facility has received this, and is ready for the survey for comprehensive level care, the facility may submit a written request for survey, noting that at least two (2) residents are receiving comprehensive level care. *Every effort will be made to schedule the survey to occur no later than twenty-one (21) calendar days after the date specified in the letter indicating that the facility will be ready for survey.*

Please do not hesitate to contact me at 317/233-7794 with any questions you may have regarding this process.

Enclosures

Revised March 2005

BED INVENTORY
State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified)
Title 19 NF = Medicaid
NCC = Non-Certified Comprehensive
Residential Level of Care

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed

Completed by	Position	Date

Plans Approval for New Construction, Additions, or Remodeling

Before Beginning Construction or Remodeling

Prior to the commencement of any construction or remodeling at a facility or beginning construction on a new facility please ensure that any plans and specifications for that project have been approved (if required) by the Indiana State Department of Health, Division of Sanitary Engineering. The general rule is that any new construction, addition, conversion, relocation, renovation, and/or any major change in facility physical plant would require plans approval. To determine if plans are required to be submitted for any project you should contact:

- Program Director-Provider Services 317-233-7794; and
- Division of Sanitary Engineering 317-233-7588.

Also before beginning the construction or remodeling project the facility should contact Program Director-Provider Services (317-233-7794) in order to determine if supplemental application forms or supporting documentation is required for the transaction. New facilities, bed additions, conversions, facility relocations, remodeling project, etc. might have both state and federal requirements in addition to plans approval. Please ensure that all requirements will be met before beginning construction in order to ensure seamless service delivery after completion of project.

After Construction is Complete

Before occupying the area of construction or remodeling:

- Contact the Program Director-Provider Services (317-233-7794) to verify that all application materials and/or requirements have been met; and then
- Submit a "Statement of Substantial Completion - Request for Inspection" (State Form 13025 or a letter to the Program Director-Provider Services. In addition, the facility shall notify the above individuals (as appropriate), in writing, when the new construction or remodeled area is ready for the required Sanitarian and Life Safety Code/State Fire Code inspections.

<u>Important:</u>

- **The area cannot be occupied until these inspections have been conducted and released.**

- **For Licensure purposes by the Division of Long Term Care, an "occupancy permit" issued by a city/county agency is not authorization to occupy the newly constructed facility/area.**

- **The Division of Long Term Care will grant permission to occupy only after the Sanitarian and Life Safety Code/State Fire Code Inspection(s) have been conducted and released.**

Incidents

Incidents/Telephone
317-233-7442

Incidents/Voice Mail
317-233-5359

Incident and Unusual Occurrence Fax
317-233-7494

Program
Incidents are reportable unusual occurrences that are recorded and monitored to facilitate compliance with state and federal laws. All unusual occurrences reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services.

Procedure
Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division. CFR 483.13(c)(2) states that "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency)."

INDIANA STATE DEPARTMENT OF HEALTH
Division of Long Term Care

EFFECTIVE DATE: 11/15/1997
REVISED: 01/25/2006

TITLE: REPORTABLE UNUSUAL OCCURRENCES

PURPOSE: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws.

POLICY: All unusual occurrences reported to the Indiana State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services.

PROCEDURE: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the Long Term Care Division. CFR 483.13(c)(2) states that "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency)."

The following are examples of occurrences that the Long Term Care Division considers reportable under both State Rule and Federal Regulation. These occurrences will be reported by facility and will be tracked and monitored.

ABUSE - Physical, Sexual, Verbal and/or Mental (known and/or alleged)

- Abuse is the **willful** infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

    - **PHYSICAL ABUSE** – includes, but not limited to, hitting, slapping, pinching, and corporal punishment.
        - Resident to resident abuse with or without injury;
        - Staff to resident abuse with or without injury;
        - Other (visitor, relative) to resident abuse with or without injury.

    - **SEXUAL ABUSE**
        - Staff to resident;
        - Resident to resident non-consensual sexual acts;
        - Resident to resident - sexual acts when both parties are considered mentally incompetent or dependent, and injury is sustained;
        - Other (visitor, relative) to resident non-consensual sexual acts.

- **VERBAL ABUSE** – is defined as the use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident; telling a resident that he/she will never be able to see family again; belittling residents.
    - Staff to resident - any episode;
    - Resident to resident verbal threats of harm.

- **MENTAL ABUSE** – includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

    - Staff to resident - any episode;

NEGLECT – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

- Failure to provide goods and services which has resulted in resident negative outcome.

INVOLUNTARY SECLUSION – is defined as a separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term **monitored** separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

UNUSUAL DEATH

- Death of a resident that is unusual and/or the result of an accident;
- Any violent or suspicious death which has been reported to the coroner.

INJURIES OF UNKNOWN SOURCE

An injury should be classified as an *injury of unknown source* when both of the following conditions are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; **AND**
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

SIGNIFICANT INJURIES

Examples, but not inclusive of all:

- Injuries sustained while a resident is physically restrained;
- Large areas of contusions or large lacerations as defined in facility policy;
- Fractures sustained by a totally dependent resident (as defined on MDS);
- Burns greater than first degree;
- Serious unusual and/or life threatening injury;
- Choking requiring hospital treatment.
- Medication errors that caused resident harm or require extensive monitoring for 24-48 hours.

RESIDENT ELOPEMENT

- A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown;
- Any circumstance of elopement which required police notification.

EPIDEMIC OUTBREAK AND/OR, QUARANTINE

- Disease incident rate that is greater than the established baseline, based on facility infection control policy.

POISONINGS AND/OR BIO TERRORISM ACTS

UTILITY INTERRUPTION

- An interruption of more than four (4) hours in length in one or more major utilities to the facility, (such as fire alarm, sprinkler system, phone services, electrical, water supply, plumbing, i.e., sewage disposal/backup, heat or air conditioning);
- Any interruption of utility services due to non-payment.

STRUCTURAL DAMAGE

- Structural damage to building due to natural disasters such as tornadoes, flooding, earthquakes, or catastrophes.

ABANDONMENT

- Employee(s) that walks off the job leaving residents unattended which results in the facility being unable to adequately care for the residents needs and the resident(s) are in jeopardy.

MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY

- Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds have been misappropriated.

WIDESPREAD RODENT AND/OR INSECT INFESTATIONS

FIRES

- Within facility due to any cause.

FACILITY REPORTING AND INVESTIGATION INSTRUCTIONS:

Facility must contact the ISDH by telephone (317/233-7442), voice mail for incidents during business hours (317/233-5359), fax (317/233-7494) **or via e-mail** (www.in.gov/isdh) within 24 hours upon determining a situation exists (or existed) that is reportable under these guidelines. The after hours telephone number is 317/233-8115. A blank Facility Incident Reporting form (a/k/a: Unusual Occurrence form), which can be utilized, is available on web site – **www.in.gov/isdh/regsvcs/providers/contact.htm** and copy attached.

The initial report should contain:

- A brief description of the occurrence;
- Any injury sustained by a resident;
- A description of the action taken by the facility to respond to the situation;
- Action taken by the facility to prevent further occurrence while the investigation is in process.

A five (5) day follow-up report is required to include the following:

- Results of investigation;
- Plan of action/interventions implemented to prevent similar occurrences; to include corrective actions taken;
- Method in which facility will continue to monitor efficacy of interventions;
- Other persons or agencies to whom occurrence was reported, e.g., Adult Protective Services, police, etc.

If the above eight (8) points have already been included in the initial report, a five (5) day follow-up report is not necessary. This original report must indicate that it is both the initial and follow-up report.

Each occurrence will be entered into the ISDH Long Term Care database.

ISDH may call for further information.

Each occurrence will be reviewed and/or investigated during a survey.

APPLICATION FOR NEW FACILITY HOSPITAL BASED UNIT
TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in the Medicare and Medicaid Programs. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
2. Three (3) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
3. Three (3) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
4. Documentation of compliance with Civil Rights requirements (forms and instructions enclosed);
5. State Form 4332, Bed Inventory (enclosed);
6. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
7. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
8. A copy of the facility's Quality Assessment and Assurance Committee policy;
9. A proposed staffing plan based upon 20%, 50% and 100% occupancy, to ensure staffing will be in accordance with federal regulations;
10. A proposed two-week staffing schedule to demonstrate compliance with federal regulations (include all RN, LPN, CNA and QMA hours);
11. Copies of all contracts or agreements for services to cover the full range of services to be offered to residents, to include copies of licenses/certification, if applicable, for individual professionals providing services; and

In addition, the applicant must contact the Medicare Fiscal Intermediary, AdminaStar Federal (or the facility's CMS approved Fiscal Intermediary), for Form CMS-855A. The facility may reach AdminaStar Federal at 317/841-4540. The completed Form CMS-855A should be forwarded directly to AdminaStar Federal for review and recommendation for approval.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for new construction or an existing building to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval;
2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection, State Form 13025 (or A1A G407), or a letter indicating that the construction is substantially complete, to the Program Director-Provider Services, Division of Long Term Care;
3. Submit to the Division a request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code).
4. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization; however, please be advised that the facility will not be able to bill Medicare and/or Medicaid for services rendered prior to the initial certification survey and official program acceptance into these programs*);
5. Prior to the initial certification survey, the following must occur:
   (1) The Division must approve all application documents submitted; and
   (2) The designated Fiscal Intermediary must approve the CMS-855A application;
6. Once these requirements are satisfied, and the facility has provided skilled care to at least two (2) comprehensive residents, the facility may submit a written request to the Program Director-Provider Services for the initial certification survey (*every effort will be made to conduct these surveys within 21 days of the date you indicate your readiness for survey*);
7. Upon completion of the initial certification survey, the Division of Long Term Care will forward the application to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency along with the initial certification survey results;
8. CMS and/or the State Medicaid Agency will notify the facility in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F2 ☐☐ ☐☐ ☐☐ (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F4 ☐☐ ☐☐ ☐☐ (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ (MM DD YY)

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31_____

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

Office for Civil Rights
Medicare Certification
Nondiscrimination Policies and Notices

Please note that documents in PDF format require Adobe's Acrobat Reader.

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Go to 45 CFR Part 80 for the full regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to §84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Go to 45 CFR Part 84 for the full regulation.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act

and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

Go to 45 CFR Part 91 for the full regulation.

Policy Examples

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Medicare Certification
Communication with Persons Who Are Limited English Proficient

Please note that documents in PDF format require Adobe's Acrobat Reader.

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program

as respect individuals of a particular race, color, or national origin.

Go to 45 CFR Part 80 for the full regulation.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

"I Speak" Language Identification Flashcard (PDF) From the Department of Commerce, Bureau of the Census, the "I Speak" Language Identification Flashcard is written in 38 languages and can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services- http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.
- Nonvital written materials could include:
- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.

- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Medicare Certification
Auxiliary Aids and Services for Persons With Disabilities

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees "shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question." (2) Pursuant to the Department's discretion, recipients with fewer than fifteen employees may be required "to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services." (3) "Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision."

Go to 45 CFR Part 84 for the full regulation.

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or

services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent

2. Authorization to Disclose Medical Information

3. Personal Valuables

4. Financial Agreement

5. Assignment of Insurance Benefits

6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice Document:

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings

ADA Document Portal

A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic.

Medicare Certification
Requirements for Facilities with 15 or More Employees

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Go to 45 CFR Part 84 for the full regulation.

Policy Example

The following procedure incorporates appropriate minimum due process standards and may serve as a model or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

SECTION 504 GRIEVANCE PROCEDURE

It is the policy of (**insert name of facility/agency**) not to discriminate on the basis of disability. (**Insert name of facility/agency**) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the office of (**insert name, title, tel. no. of Section 504 Coordinator**), who has been designated to coordinate the efforts of (**insert name of facility/agency**) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (**insert name of facility/agency**) to

retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (**insert time frame**) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (**insert name of facility/agency**) relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (**Administrator/Chief Executive Officer/Board of Directors/etc.**) within 15 days of receiving the Section 504 Coordinator's decision.
- The (**Administrator/Chief Executive Officer/Board of Directors/etc.**) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(**Insert name of facility/agency**) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Medicare Certification
Age Discrimination Act Requirements

Please note that documents in PDF format require Adobe's Acrobat Reader.

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance, directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:

(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.
(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

For the full regulation, go to 45 CFR Part 91.

Medicare Certification Civil Rights Information Request Form

Please return the completed, signed Civil Rights Information Request form and the required attachments with your other Medicare Provider Application Materials.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE FACILITY:

a. **CMS Medicare Provider Number:**_____

b. **Name and Address of Facility:** _____

_____

_____

c. **Administrator's Name** _____

d. **Contact Person** _____
(If different from Administrator)

e. **Telephone** _____ **TDD** _____

f. **E-mail** _____ **FAX** _____

g. **Type of Facility** _____
(e.g., Home Health Agency, Hospital, Skilled Nursing Facility, etc.)

h. **Number of employees:** _____

i. **Corporate Affiliation** _____ (if the facility is now or will be owned and operated by a corporate chain or multi-site business entity, identify the entity.)

j. **Reason for Application** _____
(Initial Medicare Certification, change of ownership, etc.)

PLEASE RETURN THE FOLLOWING MATERIALS WITH THIS FORM.

To ensure accuracy, please consult the technical assistance materials** (www.hhs.gov/ocr/crclearance.html) **in developing your responses.

√	No.	REQUIRED ATTACHMENTS
	1.	Two original signed copies of the form HHS-690, Assurance of Compliance (www.hhs.gov/ocr/ps690.pdf). *A copy should be kept by your facility.*
Nondiscrimination Policies and Notices *Please see Nondiscrimination Policies and Notices (www.hhs.gov/ocr/nondiscriminpol.html) for the regulations and technical assistance.*		
	2.	A copy of your written notice(s) of nondiscrimination, *that provide for admission and services without regard to race, color, national origin, disability, or age, as required by Federal law. Generally, an EEO policy is not sufficient to address admission and services.*
	3.	A description of the methods used by your facility to disseminate your nondiscrimination notice(s) or policy. *If published, also identify the extent to which and to whom such policies/notices are published (e.g., general public, employees, patients/residents, community organizations, and referral sources) consistent with requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.*
	4.	Copies of brochures or newspaper articles. *If publication is one of the methods used to disseminate the policies/notices, these copies must be attached.*
	5.	A copy of facility admissions policy or policies.
Communication with Persons Who Are Limited English Proficient (LEP) *Please see Communication with Persons Who Are Limited English Proficient (LEP) (www.hhs.gov/ocr/commune.html) for technical assistance. For information on the obligation to take reasonable steps to provide meaningful access to LEP persons, including guidance on what constitutes vital written materials, and HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at www.hhs.gov/ocr/lep . This guidance is also available at http://www.lep.gov/ , along with other helpful information pertaining to language services for LEP persons.*		
	6.	*A description (or copy) of procedures used by your facility to effectively communicate with persons who have limited English proficiency, including:* 1. How you identify individuals who are LEP and in need of language assistance. 2. How language assistance measures are provided (for both oral and written communication) to persons who are LEP, consistent with Title VI requirements. *3.* How LEP persons are informed that language assistance services are available.
	7.	A list of all vital written materials provided by your facility, and the languages for which they are available. *Examples of such materials may include consent and complaint forms; intake forms with the potential for important consequences; written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services; applications to participate in a recipient's program or activity or to receive recipient benefits or service; and notices advising LEP persons of free language assistance.*

√	No.	REQUIRED ATTACHMENTS
Auxiliary Aids and Services for Persons with Disabilities *Please see Auxiliary Aids and Services for Persons with Disabilities (www.hhs.gov/ocr/auxaids.html) for technical assistance.*		
	8.	A description (or copy) of the procedures used to communicate effectively with individuals who are deaf, hearing impaired, blind, visually impaired or who have impaired sensory, manual or speaking skills, including: 1. How you identify such persons and how you determine whether interpreters or other assistive

√	No.	REQUIRED ATTACHMENTS
		services are needed. 2. Methods of providing interpreter and other services during all hours of operation as necessary for effective communication with such persons. 3. A list of available auxiliary aids and services, and how persons are informed that interpreters or other assistive services are available. 4. The procedures used to communicate with deaf or hearing impaired persons over the telephone, including TTY/TDD or access to your State Relay System, and the telephone number of your TTY/TDD or your State Relay System.
	9.	Procedures used by your facility to disseminate information to patients/residents and potential patients/residents about the existence and location of services and facilities that are accessible to persons with disabilities.
Requirements for Facilities with 15 or More Employees *Please see Requirements for Facilities with 15 or More Employees (www.hhs.gov/ocr/regfacilities.html) for technical assistance.*		
	10.	For recipients with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
	11.	For recipients with 15 or more employees: A copy or description of your facility's procedure for handling disability discrimination grievances.
Age Discrimination Act Requirements *Please see Age Discrimination Act Requirements (www.hhs.gov/ocr/agediscrim.html) for technical assistance, and for information on permitted exceptions.*		
	12.	A description or copy of any policy (ies) or practice(s) restricting or limiting admissions or services provided by your facility on the basis of age. *If such a policy or practice exists, please submit an explanation of any exception/exemption that may apply. In certain narrowly defined circumstances, age restrictions are permitted.*

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided. Failure to provide the information/data requested may delay your facility's certification for funding.

Certification: **I certify that the information provided to the Office for Civil Rights is true and correct to the best of my knowledge.**

Signature of Authorized Official: _____

Title of Authorized Official: _____

Date: _____

BED INVENTORY
State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds

Completed by	Position	Date

Indiana State Department of Health

TO: Applicants

FROM: Program Director-Provider Services
Division of Long Term Care

Re: **Request for Application for New ICF-MR Group Home**

Please find enclosed the application forms required to be completed and submitted for the opening of a new ICF-MR Group Home:

1. Application for License to Operate a Community Residential Facility (State Form 47952);
2. Assurance of Compliance (Form HHS-690) (2 copies); and
3. Intermediate Care Facility for Persons with Mental Retardation Survey Report (From HCFA-3070G).

In addition to these forms, please submit the following documents:

1. Copy of the letter from the Bureau of Developmental Disabilities' Central Office approving the development of the new home;
2. Copy of the applicant entity's registration with the Indiana Secretary of State;
3. Copy of the floor plan for the new home, to indicate resident bedroom dimensions and square footage; and
4. Letter indicating the date the home will be ready for the Life Safety Code ("LSC") inspection and the Division of Long Term Care Health survey.

Please submit the enclosed forms and requested documentation to the Program Director-Provider Services, Division of Long Term Care 4B, Indiana State Department of Health, 2 N Meridian St, Indianapolis, IN 46204-3006.

In the event that the facility will not be ready for the LSC inspection the date originally specified, immediately contact the LSC Program at 317/233-7711. Failure to communicate requested changes in scheduling could result in delays in opening the home.

After the LSC inspection has been conducted, please ask the surveyor to contact me with verbal approval releasing the inspection, so that verbal permission may be given to occupy the facility. After the facility has moved at least two residents into the home, the facility may submit a written request for the health survey.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding these requirements or the process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A COMMUNITY RESIDENTIAL FACILITY

(Pursuant to Community Residential Facilities Council)
State Form 47952 (R2/12-99)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - IDENTIFYING INFORMATION

Name of applicant *(operator(s) of the facility/home)*			
Street Address			P.O. Box
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*
Name of Executive Director			

SECTON II – TYPE OF ENTITY

For Profit

- ☐ Individual
- ☐ * Partnership
- ☐ ** Corporation
- ☐ *** Limited Liability Company
- ☐ Other *(specify)* _____

_____

_____

Nonprofit

- ☐ Church Related
- ☐ Individual
- ☐ * Partnership
- ☐ ** Corporation
- ☐ *** Limited Liability Company
- ☐ Other *(specify)* _____

_____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION III – RESIDENTIAL FACILITY INFORMATION

A. Address

Street Address		City
County	Zip Code +4	Telephone Number ( )

B. Administrator

Name of Administrator
Qualifications

C. Program Director

Name of Program Director

Qualifications

SECTION IV – TYPE OF PROGRAM

☐ Child Rearing with Specialized Program ☐ Child Rearing ☐ Intensive Training (IT)

☐ Sheltered Living (SL) ☐ Basic Developmental (BD) Number of Residents_____

☐ Small Behavior Management Residence for Children

SECTION V – TYPE OF APPLICATION

Building Type: ☐ House ☐ Apartment

☐ Proposed New Construction

☐ Alteration of Existing House

☐ Other *(Please Explain):*_____

_____

_____

Does applicant own house? ☐ Yes ☐ No

Is applicant buying house? ☐ Yes ☐ No

Is applicant leasing house? ☐ Yes ☐ No

Note: If house is being leased, submit copy of lease.

SECTION VI – COMPLIANCE WITH RULES

Have you read, and do you understand, the Community Residential Facilities Council Rules? ☐ Yes ☐ No
(431 IAC 1.1, 431 IAC 3.1 and 431 IAC 4)

Will you comply with all laws and rules of the Community Residential Facilities Council as they pertain to the operation of licensed residential facilities for the developmentally disabled? ☐ Yes ☐ No

Does this home agree not to discriminate based on race, color creed, or national origin as provided for in operational policies? ☐ Yes ☐ No

SECTION VII – CERTIFICATION OF APPLICATION

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge, and that I will comply with all laws and rules governing the licensing of residential facilities for the developmentally disabled in Indiana.

Name of authorized representative *(typed)*	Title
Signature	Date

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No. W1

9. State/Region code W2	10. State/County code W3	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5

12. Type of Ownership or Control (enter number in box below) W6

☐ 1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other *(specify)* _____

13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? W7

☐ Yes ☐ No

14. If "Yes" to block 13, indicate either W8

A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. .....

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QMRP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify) _____		
N. Total number of Surveyors onsite	W11	
O. Total number of QMRP Surveyors onsite	W12	

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel W23
(483.430(d)(3)) .....

B. Registered Nurse W24
(483.480(d)(3)) .....

C. Licensed Voc./Practical Nurse W25
(483.480(d)(2)) .....

D. Total Personnel (W26) .....
(List the Full Time Equivalent for all employees)

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(check one)* ☐ Yes ☐ No W13
If *"No"*, proceed to item C.

B. If *"Yes,"* indicate name and address of larger organization.

Name

Address

City	State	ZIP Code

Name of CEO

Total Number of Beds W14

Total Number of Clients W15
(including ICF/MR clients directly served)

C. Total Number of ICF/MR Clients W16

D. Is this ICF/MR community-based? *(check one)* ..... ☐ Yes ☐ No W17

E. Total number of ICF/MR beds under this Provider No. W18

F. Total number of discrete living units under this Provider No. W19

G. Age range of clients served ..... *from* W20 *to* W21

H. Total number of off-campus day program sites used by ICF/MR clients W22

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs? W27

B. In how many off-campus day program sites was an observation done by the Surveyor? W28

20. Individual Characteristics *(Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)*

A.

(1) Age

under 22(a) W29

22-45 (b) W30

46-65 (c) W31

66+ (d) W32

[redacted] Total W33

(2) SEX

Male W34

Female W35

[redacted] Total W36

B. DISABILITIES

(1) Mental Retardation

Mild W37

Moderate W38

Severe W39

Profound W40

[redacted] Total W41

(2) Autism W42

(3) Cerebral Palsy W43

(4) Epilepsy

Controlled W44

Uncontrolled W45

[redacted] Total W46

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile W47

Non-Mobile W48

[redacted] Total W49

(2) Speech/Language Impairment W50

(3) Hearing Impairment

Hard of Hearing W51

Deaf W52

[redacted] Total W53

(4) Visual Impairment

Impaired W54

Blind W55

[redacted] Total W56

D. MEDICAL CARE PLAN W57

E. DRUGS TO CONTROL BEHAVIOR W58

F. PHYSICAL RESTRAINTS W59

G. TIME-OUT ROOMS W60

H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI W61

I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS W62

J. NUMBER OF COURT ORDERED ADMISSIONS W63

K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT W64

L. OTHER *(specify)*

(1) W65

(2) W66

(3) W67

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a)	W68
no. of allegations of neglect investigated (b)	W69
[redacted] Total	W70

N. NUMBER OF DEATHS

no. of deaths related to unusual incidents (a)	W71
no. of deaths related to restraints (b)	W72
no. of deaths for any reason (c)	W73
[redacted] Total	W74

Indiana State Department of Health

Division of Long Term Care

APPLICATION FOR NEW FACILITY
TITLE 19 NF

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in Medicaid Program. For additional information on the rules and regulations involving this action please refer to:
http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, to include required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments (State Form 51996 enclosed);
5. Completed Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
6. Two (2) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
7. State Form 4332, Bed Inventory (enclosed);
8. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
9. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
10. A copy of the facility's Quality Assessment and Assurance Committee policy;
11. A proposed staffing plan based upon 20%, 50% and 100% occupancy, to ensure staffing will be in accordance with federal regulations;
12. An proposed two-week staffing schedule to demonstrate compliance with federal regulations (include all RN, LPN, CNA and QMA hours);
13. Staffing plan to include the number, educational level, and personal health of employees;
14. Copies of all contracts or agreements for services to cover the full range of services to be offered to residents, to include copies of licenses/certification, if applicable, for individual professionals providing services; and
15. Copy of the facility's disaster plan.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for new construction or an existing building to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval;
2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection, State Form 13025 (or A1A G407), or a letter indicating that the construction is substantially complete, to the Program Director-Provider Services, Division of Long Term Care;
3. Submit the following documents in order for the Division of Long Term Care to grant authorization to occupy the facility:
    (1) Completed State Form 8200, Application For License To Operate A Health Facility, to include all required attachments;
    (2) Documentation of the applicant entity's registration with the Indiana Secretary of State;
    (3) Completed State Form 51996, Independent Verification of Assets and Liabilities, to include required attachments;
    (4) Request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) to the Program Director-Provider Services, Division of Long Term Care;
4. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization; however, please be advised that the facility will not be able to bill Medicaid for services rendered prior to the initial certification survey and official program acceptance*);
5. Prior to the initial licensure and certification surveys, the Division must approve all application documents submitted;
6. Once these requirements are satisfied, and the facility has provided skilled care to at least two (2) comprehensive residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure and certification surveys (*every effort will be made to conduct these surveys within 21 days of the date you indicate your readiness for survey*);
7. Upon completion of your initial licensure and certification surveys, the Division of Long Term Care will forward your application to the State Medicaid Agency along with your initial certification survey results;
8. The State Medicaid Agency will notify you in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Othe**r_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	*Number of Beds in Each Category* (to be licensed)	2. Certification Designation	*Number of Beds in Each Category* (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds		**Total Certified Beds**	

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

   If yes, explain_____

   _____

   Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
   (*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
   ☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed* **summary of the events and circumstances. Include state, dates and names of facilities)**

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

_____

_____

_____

_____

_____

_____

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:*_____*)*** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd)	To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B			
Street Address			P.O. Box
City	State	Zip Code + 4	

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $** _____

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

Form CMS-671 (12/02)

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds

Completed by	Position	Date

APPLICATION FOR NEW FACILITY
TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in the Medicare and Medicaid Programs. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application for License to Operate a Health Facility, to include required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification of Assets and Liabilities, to include required attachments (State Form 51996 enclosed);
5. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
6. Three (3) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
7. Three (3) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
8. Documentation of compliance with Civil Rights requirements (forms and instructions enclosed);
9. State Form 4332, Bed Inventory (enclosed);
10. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
11. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
12. A copy of the facility's Quality Assessment and Assurance Committee policy;
13. A proposed staffing plan based upon 20%, 50% and 100% occupancy, to ensure staffing will be in accordance with federal regulations;

14. A proposed two-week staffing schedule to demonstrate compliance with federal regulations (include all RN, LPN, CNA and QMA hours);

15. Staffing plan to include the number, educational level, and personal health of employees;

16. Copies of all contracts or agreements for services to cover the full range of services to be offered to residents, to include copies of licenses/certification, if applicable, for individual professionals providing services; and

17. Copy of the facility's disaster plan.

In addition, the applicant must contact the Medicare Fiscal Intermediary, AdminaStar Federal (or the facility's CMS approved Fiscal Intermediary), for Form CMS-855A. The facility may reach AdminaStar Federal at 317/841-4540. The completed Form CMS-855A should be forwarded directly to AdminaStar Federal for review and recommendation for approval.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for <u>new construction</u> or an <u>existing building</u> to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval;

2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection, State Form 13025 (or A1A G407), or a letter indicating that the construction is substantially complete, to the Program Director-Provider Services, Division of Long Term Care;

3. Submit the following documents in order for the Division of Long Term Care to grant authorization to occupy the facility:

(1) Completed State Form 8200, Application For License To Operate A Health Facility, to include all required attachments;

(2) Documentation of the applicant entity's registration with the Indiana Secretary of State;

(3) Completed State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments;

(4) Request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) to the Program Director-Provider Services, Division of Long Term Care;

4. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization; however, please be advised that the facility will not be able to bill Medicare and/or Medicaid for services rendered prior to the initial certification survey and official program acceptance into these programs*);

5. Prior to the initial licensure and certification surveys, the following <u>must</u> occur:

(1) The Division must approve all application documents submitted; and

(2) The designated Fiscal Intermediary must approve the CMS-855A application;

6. Once these requirements are satisfied, and the facility has provided skilled care to at least two (2) comprehensive residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure and certification surveys (*every effort will be made to conduct these surveys within 21 days of the date you indicate your readiness for survey*);

7. Upon completion of the initial licensure and certification surveys, the Division of Long Term Care will forward the application to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency along with the initial certification survey results;

8. CMS and/or the State Medicaid Agency will notify the facility in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

Revised March 2005

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Othe**r_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	*Number of Beds in Each Category* (to be licensed)	2. Certification Designation	*Number of Beds in Each Category* (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds		**Total Certified Beds**	

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

If yes, explain_____

_____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
(*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed* **summary of the events and circumstances. Include state, dates and names of facilities)**

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility		
Street Address		
City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

_____

_____

_____

_____

_____

_____

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:*_____*)*** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:			
Street Address			
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd)	To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B			
Street Address			P.O. Box
City	State	Zip Code + 4	

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	

Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $** _____

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F2 ☐☐ ☐☐ ☐☐ (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F4 ☐☐ ☐☐ ☐☐ (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ (MM DD YY)

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F29_____

Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31_____

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

Office for Civil Rights
Medicare Certification
Nondiscrimination Policies and Notices

Please note that documents in PDF format require Adobe's Acrobat Reader.

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Go to 45 CFR Part 80 for the full regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to §84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Go to 45 CFR Part 84 for the full regulation.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

Go to 45 CFR Part 91 for the full regulation.

Policy Examples

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Medicare Certification
Communication with Persons Who Are Limited English Proficient

Please note that documents in PDF format require Adobe's Acrobat Reader.

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or

methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Go to 45 CFR Part 80 for the full regulation.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

"I Speak" Language Identification Flashcard (PDF) From the Department of Commerce, Bureau of the Census, the "I Speak" Language Identification Flashcard is written in 38 languages and can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services- http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.
- Nonvital written materials could include:
- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.

- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Medicare Certification
Auxiliary Aids and Services for Persons With Disabilities

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to

beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees "shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question." (2) Pursuant to the Department's discretion, recipients with fewer than fifteen employees may be required "to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services." (3) "Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision."

Go to 45 CFR Part 84 for the full regulation.

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent

2. Authorization to Disclose Medical Information

3. Personal Valuables

4. Financial Agreement

5. Assignment of Insurance Benefits

6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice Document:

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings

ADA Document Portal
A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic.

Medicare Certification
Requirements for Facilities with 15 or More Employees

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Go to 45 CFR Part 84 for the full regulation.

Policy Example

The following procedure incorporates appropriate minimum due process standards and may serve as a model or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

SECTION 504 GRIEVANCE PROCEDURE

It is the policy of (**insert name of facility/agency**) not to discriminate on the basis of disability. (**Insert name of facility/agency**) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the office of (**insert name, title, tel. no. of Section 504 Coordinator**), who has been designated to coordinate the efforts of (**insert name of facility/agency**) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (**insert name of facility/agency**) to

retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (**insert time frame**) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (**insert name of facility/agency**) relating to such grievances.
- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (**Administrator/Chief Executive Officer/Board of Directors/etc.**) within 15 days of receiving the Section 504 Coordinator's decision.
- The (**Administrator/Chief Executive Officer/Board of Directors/etc.**) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(**Insert name of facility/agency**) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Medicare Certification
Age Discrimination Act Requirements

Please note that documents in PDF format require Adobe's Acrobat Reader.

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance, directly or

through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.
(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

For the full regulation, go to 45 CFR Part 91.

Medicare Certification Civil Rights Information Request Form

Please return the completed, signed Civil Rights Information Request form and the required attachments with your other Medicare Provider Application Materials.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE FACILITY:

a. **CMS Medicare Provider Number:**_____

b. **Name and Address of Facility:** _____

_____

_____

c. **Administrator's Name** _____

d. **Contact Person** _____
(If different from Administrator)

e. **Telephone** _____ **TDD** _____

f. **E-mail** _____ **FAX** _____

g. **Type of Facility** _____
(e.g., Home Health Agency, Hospital, Skilled Nursing Facility, etc.)

h. **Number of employees:** _____

i. **Corporate Affiliation** _____ (if the facility is now or will be owned and operated by a corporate chain or multi-site business entity, identify the entity.)

j. **Reason for Application** _____
(Initial Medicare Certification, change of ownership, etc.)

PLEASE RETURN THE FOLLOWING MATERIALS WITH THIS FORM.

To ensure accuracy, please consult the technical assistance materials** (www.hhs.gov/ocr/crclearance.html) **in developing your responses.

√	No.	REQUIRED ATTACHMENTS
	1.	Two original signed copies of the form HHS-690, Assurance of Compliance (www.hhs.gov/ocr/ps690.pdf). *A copy should be kept by your facility.*
Nondiscrimination Policies and Notices *Please see Nondiscrimination Policies and Notices (www.hhs.gov/ocr/nondiscriminpol.html) for the regulations and technical assistance.*		
	2.	A copy of your written notice(s) of nondiscrimination, *that provide for admission and services without regard to race, color, national origin, disability, or age, as required by Federal law. Generally, an EEO policy is not sufficient to address admission and services.*
	3.	A description of the methods used by your facility to disseminate your nondiscrimination notice(s) or policy. *If published, also identify the extent to which and to whom such policies/notices are published (e.g., general public, employees, patients/residents, community organizations, and referral sources) consistent with requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.*
	4.	Copies of brochures or newspaper articles. *If publication is one of the methods used to disseminate the policies/notices, these copies must be attached.*
	5.	A copy of facility admissions policy or policies.
Communication with Persons Who Are Limited English Proficient (LEP) *Please see Communication with Persons Who Are Limited English Proficient (LEP) (www.hhs.gov/ocr/commune.html) for technical assistance. For information on the obligation to take reasonable steps to provide meaningful access to LEP persons, including guidance on what constitutes vital written materials, and HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at www.hhs.gov/ocr/lep . This guidance is also available at http://www.lep.gov/ , along with other helpful information pertaining to language services for LEP persons.*		
	6.	*A description (or copy) of procedures used by your facility to effectively communicate with persons who have limited English proficiency, including:* 1. How you identify individuals who are LEP and in need of language assistance. 2. How language assistance measures are provided (for both oral and written communication) to persons who are LEP, consistent with Title VI requirements. *3.* How LEP persons are informed that language assistance services are available.
	7.	A list of all vital written materials provided by your facility, and the languages for which they are available. *Examples of such materials may include consent and complaint forms; intake forms with the potential for important consequences; written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services; applications to participate in a recipient's program or activity or to receive recipient benefits or service; and notices advising LEP persons of free language assistance.*

√	No.	REQUIRED ATTACHMENTS
Auxiliary Aids and Services for Persons with Disabilities *Please see Auxiliary Aids and Services for Persons with Disabilities (www.hhs.gov/ocr/auxaids.html) for technical assistance.*		
	8.	A description (or copy) of the procedures used to communicate effectively with individuals who are deaf, hearing impaired, blind, visually impaired or who have impaired sensory,

√	No.	REQUIRED ATTACHMENTS
		manual or speaking skills, including: 1. How you identify such persons and how you determine whether interpreters or other assistive services are needed. 2. Methods of providing interpreter and other services during all hours of operation as necessary for effective communication with such persons. 3. A list of available auxiliary aids and services, and how persons are informed that interpreters or other assistive services are available. 4. The procedures used to communicate with deaf or hearing impaired persons over the telephone, including TTY/TDD or access to your State Relay System, and the telephone number of your TTY/TDD or your State Relay System.
	9.	Procedures used by your facility to disseminate information to patients/residents and potential patients/residents about the existence and location of services and facilities that are accessible to persons with disabilities.
Requirements for Facilities with 15 or More Employees *Please see Requirements for Facilities with 15 or More Employees (www.hhs.gov/ocr/regfacilities.html) for technical assistance.*		
	10.	For recipients with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
	11.	For recipients with 15 or more employees: A copy or description of your facility's procedure for handling disability discrimination grievances.
Age Discrimination Act Requirements *Please see Age Discrimination Act Requirements (www.hhs.gov/ocr/agediscrim.html) for technical assistance, and for information on permitted exceptions.*		
	12.	A description or copy of any policy (ies) or practice(s) restricting or limiting admissions or services provided by your facility on the basis of age. *If such a policy or practice exists, please submit an explanation of any exception/exemption that may apply. In certain narrowly defined circumstances, age restrictions are permitted.*

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided. Failure to provide the information/data requested may delay your facility's certification for funding.

Certification: **I certify that the information provided to the Office for Civil Rights is true and correct to the best of my knowledge.**

Signature of Authorized Official: _____

Title of Authorized Official: _____

Date: _____

BED INVENTORY
State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Room No.	No. Beds
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

Completed by	Position	Date

Indiana State Department of Health

Division of Long Term Care

APPLICATION FOR NEW FACILITY
RESIDENTIAL CARE

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for license to operate a residential care facility. For additional information on the rules and regulations involving this action please refer to:
http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, to include required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments (enclosed);
5. State Form 4332, Bed Inventory (enclosed);
6. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
7. A staffing plan that should include the number, educational level and personal health of employees;
8. Agreements/Contracts between the applicant entity with various providers of services for residents within the facility:
   a. Dietician;
   b. Emergency Shelter;
   c. Emergency Water Supply;
   d. Hospital Transfer Agreement(s) (if applicable, but not required);
   e. Pharmacy Services; and
   f. Pharmacy Consultant Services (if applicable).

   NOTE: Facilities with contracts for services which require a licensed and/or certified professional should include copies of the licenses and/or certification for the individuals who will be providing the services.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for <u>new construction</u> or an <u>existing building</u> to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval;

2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection, State Form 13025 (or A1A G407) to the Program Director-Provider Services, Division of Long Term Care;
3. Submit the following documents in order for the Division of Long Term Care to grant authorization to occupy the facility:
    (1) Completed State Form 8200, Application For License To Operate A Health Facility, to include all required attachments;
    (2) Documentation of the applicant entity's registration with the Indiana Secretary of State;
    (3) Completed State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments;
    (4) Request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) to the Program Director-Provider Services, Division of Long Term Care;
4. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization);*
5. Once these requirements are satisfied, and the facility has provided residential care to at least two (2) residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure survey;
6. Upon completion of the initial licensure survey, the Division of Long Term Care will forward the survey results.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/8-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Othe**r_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. Level of Care	*Number of Beds in Each Category* (to be licensed)	**2. Certification Designation**	*Number of Beds in Each Category* (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds		**Total Certified Beds**	

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
(If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT
(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

If yes, explain_____

_____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
(*If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)*

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed* **summary of the events and circumstances. Include state, dates and names of facilities)**

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City	State	Zip+4

SECTION A

This health facility ρ does ρ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ρ does ρ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ρ yes ρ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

_____

_____

_____

_____

_____

_____

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHE THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES
State Form 51996 (R1/6-05)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee:	CPA:
1. Complete sections I, II, and section III, F and G. 2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process. 3. Forward the completed materials to a Certified Public Accountant. 4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation. 2. Using agreed upon procedures; verify items in section IV, F. 3. Sign and date the certification statement as indicated in Section IV (CPA). 4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.

Please Type or Print Legibly

SECTION I – TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease:*_____)** ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:		
Street Address		
City	County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From (mm/dd) To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B		
Street Address		P.O. Box
City	State	Zip Code + 4

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF_____
(date)

A. Current Assets:		**B. Current Liabilities:**	
Asset	***Amount (rounded to nearest dollar)***	***Liability***	***Amount (rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	

All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: (Total Current Assets minus Total Current Liabilities) $_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $** _____

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION IV – CERTIFICATION STATEMENTS

Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date**

This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself (us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).

Name of Certified Public Accountant representing the firm (*Typed*)	**Title/Position**	
Signature of Certified Public Accountant representing the firm	**License/Certification Number**	**Date**

BED INVENTORY

State Form 4332 (R8/1-02)
Indiana State Department of Health-Division of Long Term Care

Name of Facility		
Street Address		
City	County	Zip+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds **NCC = Non-Certified Comprehensive**
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) **Residential Level of Care**
Title 19 NF = Medicaid

All licensed beds must be listed.

Room No.	**No. Beds**
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		**Title 18/19 SNF/NF**		**Title 19 NF**				**NCC**		**Residential**	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds

Completed by	Position	Date

Plans Approval for New Construction, Additions, or Remodeling

Before Beginning Construction or Remodeling

Prior to the commencement of any construction or remodeling at a facility or beginning construction on a new facility please ensure that any plans and specifications for that project have been approved (if required) by the Indiana State Department of Health, Division of Sanitary Engineering. The general rule is that any new construction, addition, conversion, relocation, renovation, and/or any major change in facility physical plant would require plans approval. To determine if plans are required to be submitted for any project you should contact:

- Program Director-Provider Services 317-233-7794; and
- Division of Sanitary Engineering 317-233-7588.

Also before beginning the construction or remodeling project the facility should contact Program Director-Provider Services (317-233-7794) in order to determine if supplemental application forms or supporting documentation is required for the transaction. New facilities, bed additions, conversions, facility relocations, remodeling project, etc. might have both state and federal requirements in addition to plans approval. Please ensure that all requirements will be met before beginning construction in order to ensure seamless service delivery after completion of project.

After Construction is Complete

Before occupying the area of construction or remodeling:

- Contact the Program Director-Provider Services (317-233-7794) to verify that all application materials and/or requirements have been met; and then
- Submit a "Statement of Substantial Completion - Request for Inspection" (State Form 13025 or a letter to the Program Director-Provider Services. In addition, the facility shall notify the above individuals (as appropriate), in writing, when the new construction or remodeled area is ready for the required Sanitarian and Life Safety Code/State Fire Code inspections.

<u>Important:</u>

- **The area cannot be occupied until these inspections have been conducted and released.**

- **For Licensure purposes by the Division of Long Term Care, an "occupancy permit" issued by a city/county agency is not authorization to occupy the newly constructed facility/area.**

- **The Division of Long Term Care will grant permission to occupy only after the Sanitarian and Life Safety Code/State Fire Code Inspection(s) have been conducted and released.**

Licensure Renewal

Pursuant to 410 IAC 16.2-3.1-2, for the renewal of a license, the director may issue a full license for any period up to one (1) year, issue a probationary license, or deny a license application upon receipt and review of the following requirements:

- The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license. The renewal application shall be on a form provided and approved by the division.
- The applicant shall identify direct or indirect ownership interests of five percent (5%) or more and of officers, directors, and partners.
- The applicant shall submit the appropriate license fee. The licensure fee, made payable by check or money order to the Indiana State Department of Health in the amount of two hundred dollars ($200.00) for the first fifty (50) beds; ten dollars ($10.00) for each additional bed.
- The director shall verify that the facility is operated in reasonable compliance with IC 16-28-2 and this article.
- The state fire marshal shall verify that the facility is in reasonable compliance with the applicable fire safety statutes and rules (675 IAC).
- If the director issues a probationary license, the license may be granted for a period of three (3) months. However, no more than three (3) probationary licenses may be issued in a twelve (12) month period. Although the license fee for a full twelve (12) month period has been paid, a new fee shall be required prior to the issuance of a probationary license.

- State Form 1714 Application for Renewal of Health Facility License

Minimum Data Set ("MDS") Contact Information

Clinical questions may be addressed to:

MDS Clinical Coordinator
317/233-4719

Technical questions may be addressed to:

MDS Technical Help Desk
317/233-7206

Nurse Aide Registry

Nurse Aide Registry General Information Line:	317-232-0803 317-233-7639
Nurse Aide Registry General Fax Number:	317-233-7750
QMA and CAN training programs:	317-233-7615
Automated Registry Information:	317-233-7612

The purpose of the Nurse Aide Registry is to establish a list of Certified Nurse Aides for the state of Indiana which serves as an employment reference and check of certification, as well as keeping track of complaints and findings against nurse aides to prohibit employment. The registry is a computerized listing of nurse aides who **have** completed the training and certification process including the 105-hr course and test.

The registry is a federally mandated program and requires that the state provide information to callers regarding the certification of aides, findings or complaints on their records and general information about the Registry process.

A list of nurse aides who have verified findings on their Registry records is updated every two (2) weeks by the Indiana State Department of Health ("Department") on the web page. It is a requirement that facilities call the Registry to determine the status of each and every nurse aide who seeks employment. Nurse aides who have findings on their Registry records may not be employed in Indiana or elsewhere. Many of these aides continue to seek employment knowing full well they are prohibited from doing so.

The criminal history law also prohibits the employment of aides and other non-licensed personnel if they have been convicted of certain crimes. This is an Indiana law and it includes facilities as well as employment agencies and nursing "pools". Criminal history information can be obtained from the:

INDIANA STATE POLICE CENTRAL REPOSITORY
INDIANA GOVERNMENT CENTER - NORTH
100 SENATE AVENUE - ROOM 302
INDIANAPOLIS, INDIANA 46206
Telephone: 317-232-8262

Please be advised that the criminal history law is not a requirement of the Nurse Aide Registry. It is **Indiana law** and you should obtain copies of this law from your attorney or legal counsel in order to understand the law and fully comply. The Registry is interested in criminal history information about aides and you should send copies of such information to the Registry. The Criminal History Law is in the Indiana Code: IC 16-28-13.

The Registry has an automated telephone answering system which operates 24 hours a day 7 days a week. It is the quickest and easiest way to obtain CNA information. This system will also tell you if the CNA has a complaint on record and is not employable. You will need to have the Social Security Number of the aide to use the system. The Registry Automated Number is 317/233-7612**.**

Access Indiana (http://www.in.gov/) is a website that facilities can use to obtain information on CNA's, HHA, and QMA's. The cost is fifty ($50) dollars per year for a subscription and one ($1) dollar per aid requested. This can be downloaded and printed. If is updated once a day, five days a week (no weekends).

The Registry has a limited ability to handle walk-in requests. If the CNA comes to the Indiana State Department of Health ("Department") they **MUST** bring a picture I.D., such as a driver's license, in order to obtain information.

If you need to report a complaint regarding a CNA, you should do so to the Indiana State Department of Health complaint line at **1-800-246-8909**. Reporting complaints to the Registry directly will only slow down the process. All complaints regarding a nurse aide and charges of abuse, neglect or misappropriation of a resident's property will be investigated. During this investigation, no information will be given to the facility or the aide. If a hearing is held and results in a finding against the aide, the aide and the facility will be notified by certified mail. The finding is placed on the Registry records and the aide is prohibited from working as a CNA. It is **IMPORTANT** to keep calling the Registry to obtain current status information.

ATTACHMENT 1

NURSE AIDE REGISTRY					
THE FOLLOWING INFORMATION IS A GUIDE ON HOW TO BE PLACED ON THE NURSE AIDE REGISTRY:					
STATUS	**COURSE**	**RECIPROCITY**	**EMPLOYMENT**	**PROF. RESOURCES**	**PLACED ON REGISTRY**
TRAINEE	105-hr. Course & Practicum	⇨	⇨	Test	X
WORKING AIDE	⇨	⇨	Verification of employment in last 24 months	⇨	X
WORKING AIDE & QMA NOT ON REGISTRY & NOT GRANDFATHERED IN	105-hr. Course & Practicum	⇨	⇨	Test	X
AIDE FROM OUT- OF-STATE	⇨	On another State Registry with good standing	Verified employment in last 24 months	Test	X
AIDE FROM OUT- OF-STATE & IS **NOT** ON THEIR REGISTRY	105-hr. Course & Practicum	NOT on another State Registry	⇨	Test	X
AIDE **NOT** WORKED IN 24 MONTHS	105-hr. Course & Practicum	⇨	⇨	Test	X
AIDE, QMA, OR TRAINEE WITH COMPLAINT ON REGISTRY	⇨	⇨	**NOT** employable in any state	⇨	Kept on registry for information purposes only

Administrator Change

Indiana Health Facilities Rules 410 IAC 16.2-3.1-13 requires that a long term care facility have a licensed administrator.

The licensee shall notify the department within three (3) working days of a vacancy in the administrator's position. The licensee shall also notify the director of the name and license number of the replacement administrator.

An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1) health facility or one (1) hospital-based long term care unit at a time.

In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf.

It is recommended that the facility submit the form below to notify the Indiana State Department of Health of a change in administrator.

If the facility does not use the form please submit written correspondence to provide notice of such change and include the following documentation:

- The name of the replacement administrator
- The license number of the replacement administrator
- The effective date for the replacement administrator

The notice and documentation should be sent to:

Licensure Secretary
Indiana State Department of Health
Division of Long Term Care, Section 4B
2 N Meridian
Indianapolis, IN 46204
Telephone: 317-233-1324
Fax: 317-233-7322

ADMINISTRATOR OR DIRECTOR OF NURSING CHANGE FORM

Indiana State Department of Health-Division of Long Term Care

The Indiana State Department of Health must be notified each time that a facility has a change in administrator or director of nursing. It is recommended that the following form be completed and submitted to the Indiana State Department of Health in the event of a change.

Facility Name:		
Street Address:		
City:	**State:**	**Zip Code:**

Please Check the Appropriate Box Below to Match the Correct Position Change Type ☐ ADMINISTRATOR (New) ☐ DIRECTOR OF NURSING (New)	
Name:	**License Number:**
Date Appointed:	

ADMINISTRATOR OR DIRECTOR OF NURSING (Previous)	
Name:	**License Number:**
Last Date in Position:	

Please fill out the form and fax a copy to the Indiana State Department of Health:

Attn: Licensure Secretary
Fax Number: 317-233-7322

If there are any questions please contact the Indiana State Department of Health at:

Telephone Number: 317-233-1324

Director of Nursing Change

Indiana Health Facilities Rules 410 IAC 16.2-3.1-17 specifies that a facility must designate a registered nurse who has completed a nursing management course with a clinical component or who has at least one (1) year of nursing supervision in the past five (5) years to serve as the director of nursing on a full-time basis. The director of nursing shall have, in writing, and shall exercise administrative authority, responsibility, and accountability for nursing services within the facility and shall serve only one (1) facility at a time in this capacity.

The licensee shall notify the department of a vacancy in the director of nursing position. The licensee shall also notify the director of the name and license number of the replacement director of nursing.

It is recommended that the facility submit the form below to notify the Indiana State Department of Health of a change in director of nursing.

If the facility does not use the form please submit written correspondence to provide notice of such change and include the following documentation:

- The name of the replacement director of nursing
- The license number of the replacement director of nursing
- The effective date for the replacement director of nursing

The notice and documentation should be sent to:

Licensure Secretary
Indiana State Department of Health
Division of Long Term Care, Section 4B
2 N Meridian
Indianapolis, IN 46204
Telephone: 317-233-1324
Fax: 317-233-7322

ADMINISTRATOR OR DIRECTOR OF NURSING CHANGE FORM

Indiana State Department of Health-Division of Long Term Care

The Indiana State Department of Health must be notified each time that a facility has a change in administrator or director of nursing. It is recommended that the following form be completed and submitted to the Indiana State Department of Health in the event of a change.

Facility Name:		
Street Address:		
City:	**State:**	**Zip Code:**

Please Check the Appropriate Box Below to Match the Correct Position Change Type ☐ ADMINISTRATOR (New) ☐ DIRECTOR OF NURSING (New)	
Name:	**License Number:**
Date Appointed:	

ADMINISTRATOR OR DIRECTOR OF NURSING (Previous)	
Name:	**License Number:**
Last Date in Position:	

Please fill out the form and fax a copy to the Indiana State Department of Health:

Attn: Licensure Secretary
Fax Number: 317-233-7322

If there are any questions please contact the Indiana State Department of Health at:

Telephone Number: 317-233-1324

Facility Name Change

A facility may request a change in name at any time. To request a change in name please submit a request on facility letterhead with the following information:

- Former name of facility
- Current Address of facility
- New Name of facility
- Effective Date for the change in name

The request should be submitted to:

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204
Telephone: 317-233-7794
Fax: 317-233-7322

Facility Address Change

A facility may request a change in address at any time. To request a change in address please submit a request on facility letterhead with the following information:

- Former address of facility
- Current Address of facility
- Effective Date for the change in name

The request should be submitted to:

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204
Telephone: 317-233-7794
Fax: 317-233-7322

Fiscal Intermediary Changes

A facility may request a change in fiscal intermediary. Most providers in the State of Indiana use AdminaStar Federal as their Fiscal Intermediary. However, the Centers for Medicare and Medicaid Services ("CMS") have recognized that providers might use another CMS designated fiscal intermediary.

The Division of Long Term Care is required to notify the Fiscal Intermediary of any changes affecting a facility's Medicare certified beds (increasing/decreasing the numbers and classifications).

To meet this requirement, any changes to a facility's Fiscal Intermediary should be reported to this Division in writing (after the change has been approved by the CMS) to include the following information:

- Name of Fiscal Intermediary
- Fiscal Intermediary Street Address
- Fiscal Intermediary City/State/Zip Code
- Fiscal Intermediary Telephone Number
- Fiscal Intermediary Number
- Fiscal Intermediary Contact Person

The request should be submitted to:

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204
Telephone: 317-233-7794
Fax: 317-233-7322

Inpatient Therapy Services

Providers requesting reimbursement for Inpatient Therapy Services are not required to submit a request to the Division of Long Term Care for processing and approval. Providers should contact the following agency with any questions/requests for reimbursement for Inpatient Therapy Services:

Myers and Stauffer
Certified Public Accountants
8555 North River Road, Suite 360
Indianapolis, IN 46240
Telephone: 317-846-9521
1-800-877-6927

Outpatient Therapy Services

The Division of Long Term Care has been advised by the Centers for Medicare and Medicaid Services ("CMS") that providers are not required to submit requests to the Division for approval of outpatient services (Occupational, Physical and Speech Therapy Services).

All questions regarding reimbursement for outpatient therapy services must be directed to the facility's Fiscal Intermediary.

Involuntary Transfer-Discharge General Information

A transfer discharge is deemed involuntary if it is an interfacility transfer or discharge and if it instigated by the facility. An interfacility transfer and discharge, as defined by 410 IAC 16.2-3.1-12, of residents of a facility is as follows:

- Interfacility transfer and discharge means the movement of a resident to a bed outside of the licensed facility. For Medicare and Medicaid certified facilities, an Interfacility transfer and discharge means the movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.

Note: When a transfer or discharge of a resident is proposed provision for continuity of care shall be provided by the facility.

Reasons for Interfacility Transfer-Discharge

Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:

A. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
B. The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.
C. The safety of individuals in the facility is endangered.
D. The health of individuals in the facility would otherwise be endangered.
E. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.
F. The facility ceases to operate.

Emergency Interfacility Transfer-Discharge Requirements

Notice may be made as soon as practicable before transfer or discharge when:

- The safety of individuals in the facility would be endangered.
- The health of individuals in the facility would be endangered.
- The resident's health improves sufficiently to allow a more immediate transfer or discharge.
- Immediate transfer or discharge is required by the resident's urgent medical needs.
- Resident has not resided in the facility for thirty (30) days.

Documentation Necessary for Interfacility Transfer-Discharge

When the facility proposes to transfer or discharge a resident under any of the circumstances mentioned above, the resident's clinical records must be documented. The documentation must be made by the following:

- The resident's physician when transfer or discharge under subdivision A or B.
- Any physician when transfer or discharge is necessary under subdivision D.

Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following:

- Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands.

The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following:

- The resident.
- A family member of the resident if known.
- The resident's legal representative if known.
- The local long term care ombudsman program (for involuntary relocations or discharges only).
- The person or agency responsible for the resident's placement, maintenance, and care in the facility.
- In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.
- The resident's physician when the transfer or discharge is necessary under subdivision C, D, E, or F.
- Record the reasons in the resident's clinical record.

Interfacility Transfer-Discharge Notice Requirements

The notice of transfer or discharge must be made by the facility at least thirty (30) days (unless transfer discharge is deemed an emergency transfer discharge) before the resident is transferred or discharged.

For health facilities, the written notice must include the following:
The reason for transfer or discharge.

- The effective date of transfer or discharge.
- The location to which the resident is transferred or discharged.
- A statement in not smaller than 12-point bold type that reads, "You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below.".
- The name of the director, address, telephone number, and hours of operation of the division.
- A hearing request form prescribed by the department.
- The name, address, and telephone number of the division and local long term care ombudsman.

- For facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

Interfacility Transfer-Discharge Appeal Requirements and Process

- If the resident appeals the transfer or discharge, the facility may not transfer or discharge the resident within thirty-four (34) days after the resident receives the initial transfer or discharge notice.
- If nonpayment is the basis of a transfer or discharge, the resident shall have the right to pay the balance owed to the facility up to the date of the transfer or discharge and then is entitled to remain in the facility.
- The department shall provide a resident who wishes to appeal the transfer or discharge from a facility the opportunity to file a request for a hearing postmarked within ten (10) days following the resident's receipt of the written notice of the transfer or discharge from the facility.
- If a facility resident requests a hearing, the department shall hold an informal hearing at the facility within twenty-three (23) days from the date the resident receives the notice of transfer or discharge.
- The department shall attempt to give at least five (5) days written notice to all parties prior to the informal hearing.
- The department shall issue a decision within thirty (30) days from the date the resident receives the notice.
- The facility must convince the department by a preponderance of the evidence that the transfer or discharge is authorized.
- If the department determines that the transfer is appropriate, the resident must not be required to leave the facility within the thirty-four (34) days after the resident's receipt of the initial transfer or discharge notice unless an emergency exists.
- Both the resident and the facility have the right to administrative or judicial review under IC 4-21.5 of any decision or action by the department arising under this section. If a hearing is to be held de novo, that hearing shall be held in the facility where the resident resides.

Contact Information

For assistance with the transfer and discharge process please contact:

- Program Director-Provider Services (317) 233-7794

Transfer and Discharge Forms

- Notice of Transfer Discharge (State Form 49669)
- Notice of Transfer Discharge Request for Hearing (State Form 49831)

Informal Dispute Resolution (IDR) Program Overview

Pursuant to SEA 396-2003, ISDH is to contract with an entity that has experience in conducting IDR for a state survey agency to create and operate a voluntary informal IDR pilot program for health facilities. The program must comply with the requirements under 42 CFR 488.311.

ISDH has determined that Michigan Peer Review Organization (MPRO), the Medicare Quality Improvement Organization for Michigan, complies with this requirement and has been awarded the contract.

The Indiana State Department of Health (ISDH), Long Term Care (LTC) is offering additional information and choices in the Informal Dispute Resolution (IDR) process.

- ISDH paper review-conducted by IDR Surveyor Supervisor
- ISDH face-to-face-conducted by IDR Surveyor Supervisor and one Surveyor Supervisor
- MPRO-fee for service-paper review (one nurse review)-substandard quality of care & immediate jeopardy (two nurse review)-or, requested physician review (by separate tag).

Note: A facility must select one (1) option for deficiencies affecting Medicare/Medicaid findings. MPRO will not review state findings.

For EACH deficiency, the facility must provide to ISDH:

- A one paragraph, written summary for each tag appealed explaining why the facility is disputing a particular tag.
- Copy(s) of all supporting documents with all resident names and any other identifying information obliterated (redacted) and replaced with the Resident Identifier on the 2567.
- Pertinent Portions of the record with key documentation outlined with a marker (Highlighting does not photocopy).
- Supporting documents should be labeled "Attachment A", "B", etc.
- All pages submitted should be numbered sequentially from beginning to end.

MPRO has developed a one-page service agreement that describes the fee-for service process, lists the service fees, and clarifies the commitment of both parties. The form is generic and requires the facility to insert the facility's name and the signature, name, and title of the responsible party and the date. Since MPRO must receive the signed agreement prior to initiating the requested review, the facility must submit the signed agreement with the IDR request to ISDH. IF the signed agreement is not received with the IDR request, ISDH will not forward the IDR request until receipt of the signed original agreement. Please note the ISDH will not delay enforcement actions pending results of an IDR review. Also, do not send the IDR request directly to MPRO.

MPRO will maintain a list of qualified reviewers who have signed confidentiality agreements and conflict of interest disclaimer statements. MPRO will ensure that the assigned reviewer(s) for each case has no conflict of interest.

A brief overview of MPRO's independent IDR review process is as follows:

- MPRO requires one copy of review materials for all cases: two copies for substandard quality of care/immediate jeopardy cases.
- MPRO will complete the IDR review and return a decision to ISDH within twenty (20) days of receipt of review materials from ISDH. ISDH will notify facility of the independent review decision.
- MPRO will mail an invoice to facility at the end of the month for services performed and payment is expected within thirty (30) days.

For each tag involving a deficient practice cited as immediate jeopardy or substandard quality of care, MPRO will select at least two qualified nurse reviewers to review the tag. For all other tags, MPRO shall assign one qualified nurse reviewer.

Per Centers for Medicare & Medicaid Services (CMS) letter 3-25, the results of the IDR process will serve only as a recommendation, ISDH will make the final determination. The facility will receive BOTH the MPRO recommendation letter and the ISDH final determination letter.

Instructions for Requesting Informal Dispute Resolution (IDR)

Complete the unshaded portions of the IDR Tracking Record. Select one of the following: an ISDH paper review, an ISDH face-to-face review, or a MPRO paper review. The fact that a tag is being disputed must also be clearly stated on the Plan of Correction (POC). Include on a separate document from the POC, a one paragraph written summary of the reasons for the dispute for each tag, referencing supporting documents. Include the tag number and resolution proposed, i.e., remove tag, etc. If supporting documentation will accompany the IDR request, please only submit one copy at the same time you submit the POC; unless choosing MPRO review for substandard quality of care/immediate jeopardy, then two copies are required. Corrective actions must be specified on the POC, as if the tag were not being disputed. If selecting MPRO review, do not send the IDR request directly to MPRO. ISDH will forward all submitted documentation to MPRO.

Note: A facility cannot choose more than one (1) option for federal deficiencies (for deficiencies affecting Medicare/Medicaid findings). MPRO is not an option for state findings only.

A service agreement has been developed by MPRO. If selecting MPRO review, the facility administrator of designee must complete the appropriate portion of the service agreement and submit the IDR request. MPRO will complete the IDR review and return a decision to ISDH within twenty (20) days of receipt of review materials. MPRO will mail an invoice to the facility at the end of the month for services performed and payment is expected within thirty (30) days.

Ensure that the IDR request and POC are submitted within ten (10) calendar days of facility's receipt of the CMS-2567. A facsimile copy is acceptable. The IDR request must be submitted at the same time as the POC. The POC will be forwarded to the appropriate survey supervisor for review and approval, and the IDR request will be forwarded to the IDR survey supervisor. For cases involving deficient practices cited at the immediate jeopardy or substandard quality of care, both MPRO and ISDH will select at least two qualified nurse reviewers to review the case. For all other cases, MPRO shall assign one qualified nurse reviewer.

IDR Process

The IDR process will be conducted a review of the materials submitted at the time of the request for IDR. All documents and materials that are to be considered for either face-to face or paper review must be included at the time of the IDR request. The description of the dispute for each tag must be a clear and concise statement. State explicitly what is disputed and why it is being disputed, cite specific errors, and where support for the dispute is located in supporting documents. Pertinent portions of supporting documents should be outlined with a marker. Supporting documents should be labeled "Attachment A", "B", etc. A statement that the facts asserted on the CMS-2567 are not supported (or similar statement) is not sufficient.

Note: Only documents that are pertinent and necessary to explain the facility's position will be considered. Excessive numbers of documents should not be submitted.

ISDH will provide written notice to the facility of the outcome of the IDR process. If MPRO review is selected the facility will receive both the MPRO recommendation letter and the ISDH final determination letter.

Additional Information about IDR

Only deficiencies cited on the current survey, originally identified on the CMS-2567, may be disputed. Any evidence submitted to refute deficiencies must pertain only to the deficiencies and the language of the regulation cited. Only documents that are relevant to the dispute, and which were in existence at the time of the survey, will be considered.

IDR does not contemplate bargaining between providers and the ISDH; rather it is a preliminary opportunity to refute survey findings that are believed to be inaccurate and to present evidence to support that belief. The purpose of this process is to give providers one opportunity to dispute cited deficiencies after a survey. The IDR process may not be used to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including but not limited to:

- Classification of deficiencies, i.e., scope and severity assessments
- Remedies imposed by the enforcement agency
- Failure of the survey team to comply with a requirement of the survey process
- Inconsistency of the survey team in citing deficiencies among facilities
- Inadequacy of the IDR process

IDR Forms

- Regulatory Services Informal Dispute Resolution (IDR) Record (State Form 50058)
- MPRO Service Agreement Form

Contact Information

Scheduling: IDR Secretary- (317) 233-7002
Status of Current IDR: **suscott@isdh.in.gov**

Area Supervisor Responsibilities

Area Supervisors are responsible for the supervision of field surveyors in an assigned area of the state. The area supervisors are also responsible for the following activities:

- Assuring that annual recertification surveys, state only surveys, complaints, and revisits to open surveys are scheduled and completed in a timely manner.
- Reviewing and approving plans of correction
- Assessing the performance of field surveyors
- Answering provider questions regarding the survey process

Area Supervisor Coverage List

Area 1: 317-233-7617
Benton, Boone, Carroll, Cass, Clinton, Fountain, Howard, Jasper, Lake, Laporte, Montgomery, Newton, Porter, Pulaski, Starke, Tippecanoe, Tipton, Warren

Area 2: 317-233-7321
Adams, Allen, DeKalb, Elkhart, Fulton, Koskiusko, LaGrange, Marshall, Noble, St. Joseph, Steuben, Whitley

Area 3: 317-233-7080
Blackford, Delaware, Grant, Hamilton, Huntington, Jay, Madison, Marion, Miami, Wabash, Wells

Area 4: 317-233-7772
Marion

Area 5: 317-233-7753
Clark, Crawford, Daviess, Dubois, Floyd, Gibson, Greene, Harrison, Jackson, Knox, Lawrence, Martin, Monroe, Orange, Perry, Pike, Posey, Scott, Spencer, Vanderburgh, Warrick, Washington

Area 6: 317-233-7441
Bartholomew, Brown, Clay, Dearborn, Decatur, Fayette, Franklin, Hancock, Hendricks, Henry, Jefferson, Jennings, Johnson, Morgan, Ohio, Owen, Parke, Putnam, Randolph, Ripley, Rush, Shelby, Sullivan, Switzerland, Union, Vermillion, Vigo, Wayne

Area 1
Judi Navarro

109 facilities

Area 2
Brenda Meredith

107 facilities

Area 3
Brenda Buroker

110 facilities

Area 4
Zetra Allen

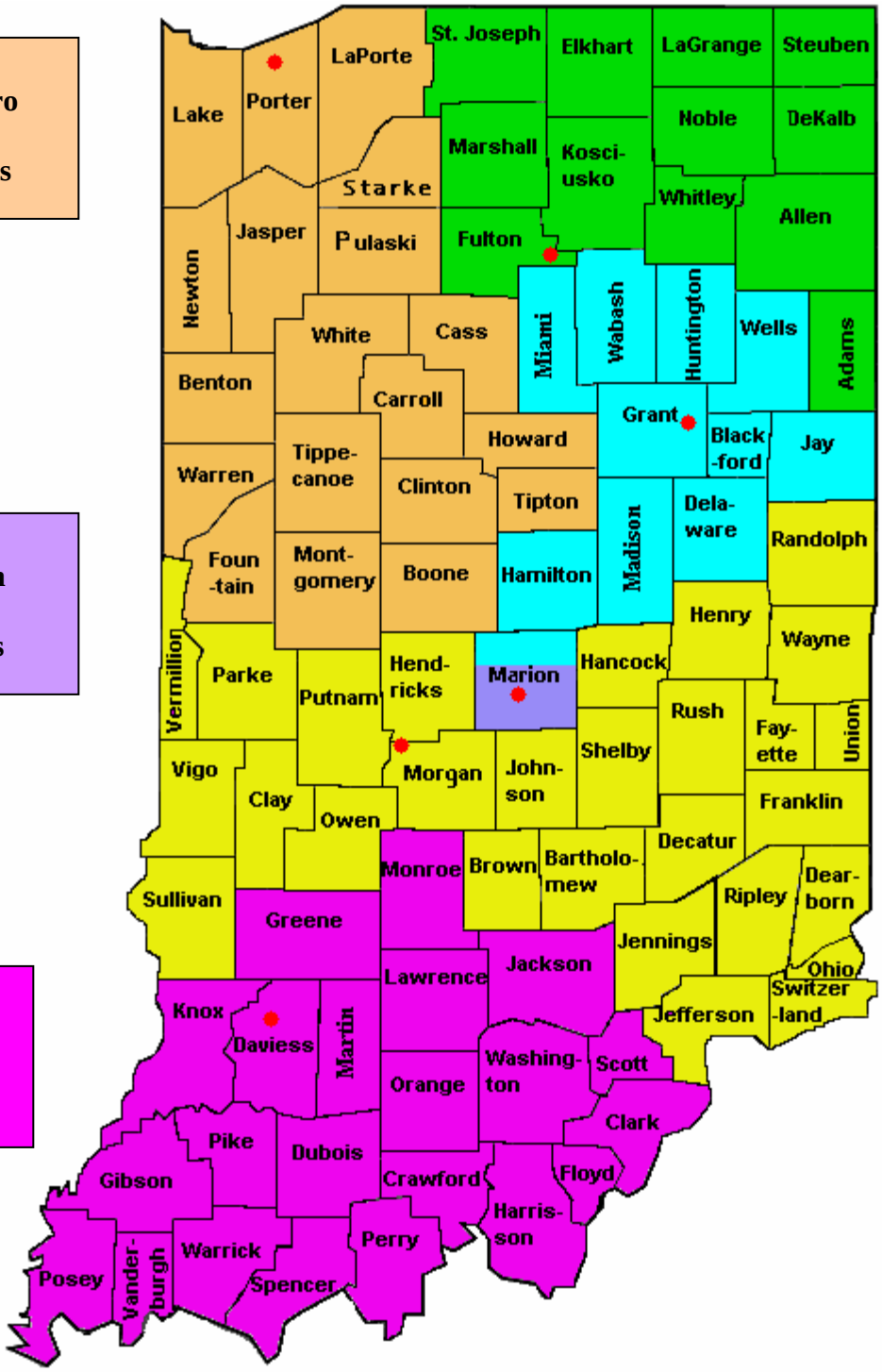
31 facilities

Area 5
Karen Powers

119 facilities

Area 6
Pat Nicolaou

114 facilities



6 AREAS – 10/31/05

● = Location of Supervisor

Admission of Children to Adult Long Term Care Facilities

In accordance with the Health Facilities Rules 410 IAC 16.2-3.1-13(g)(3), facilities must obtain approval from the Division Director of Long Term Care prior to the admission of an individual under eighteen (18) years of age to an adult long term care facility.

To request approval please submit the following for consideration of the request:

- A written request from the parent(s) or guardian(s) for admission to the facility.
- The name, age, diagnosis and a statement as to why the child is to be cared for in the facility as opposed to a facility for children.
- The physician's plan of care and list of treatments required.
- Nursing care plan addressing specific care needs.
- An indication from the facility that the facility has the necessary staff expertise to meet the physician's and nursing care plan.
- Information that the child or children will be housed in a segregated area apart from the normal Geriatric population. The intent is that the child or children be housed separately from the adult population.
- Statement on how services required under Rule 6 (Health Care Facilities for Children) will be provided.
- Statement on how services that are required under Rule 7 (Health facilities serving Developmentally Disabled), if appropriate, will be provided.
- Statement from the attending physician and the medical director that immunization of employees is not necessary for the admission of a child.
- The placement shall be for no greater time than the term of license and will be reviewed to see that the facility can continue to adequately care for the resident at the time of renewal of license.
- For respite care or for placement of less than thirty (30) days, items 7, 8 and 10 above are not necessary.

The request should be submitted to:

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204
Telephone: 317-233-7794
Fax: 317-233-7322

Admissions of Patients with Confirmed or Suspected Tuberculosis

Health Facilities Rules (410 IAC 16.2-3.1-18-D) require that each resident, prior to admission, shall be required to have a statement to show no evidence of TB in an infectious stage, as verified on admission and yearly thereafter. This specific waiver program will allow the admission of patients with confirmed or suspected tuberculosis (TB) or patients under treatment for tuberculosis to licensed long-term facilities which meet the specific criteria detailed in the Guidelines for Preventing the Transmission of Tuberculosis in Health Care Settings, 2005 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm).

No waiver will be considered by the Indiana State Department of Health ("Department") unless there is prior written assurance by the Administrator and Medical Director of the long-term care facility that these guidelines have been met. Further, the facility must have a room or rooms equipped as detailed in Guidelines for Preventing the Transmission of Tuberculosis in Health Care Settings, 2005. These assurances should be provided to the Department and will be kept on file, prior to the admission of any patient under the waiver program.

Each waiver will be specific for only one person, only for facilities which have proper assurance on file with the Department, and for a period not to exceed one year. Additional waivers will be considered or renewed as requested. The facility must demonstrate that it can meet and/or exceed the current medical guidelines as cited above. Past survey findings will be reviewed to assess the status of infection control within the facility during the past year. Upon request for admission or later verification of a communicable disease incident within a facility, an on-site visit may be made by one or more representatives of the Communicable Disease Division/Tuberculosis Control Program and/or Division of Long Term Care to verify compliance with appropriate infection control procedures. A waiver may be rescinded if at any time the Department determines that the Guidelines are not met or that proper assurances have not been given.

The request for a waiver should be directed to the Indiana State Department of Health, Division Long Term Care to the attention of the Program Director-Provider Services. The initial request for a waiver may be verbal, and permission to admit may be given verbally by the Director or his/her designee. Written confirmation must be expeditiously initiated by the facility administrator on the **"Tuberculosis Waiver Request."** This form must be signed by the administrator, medical director and attending physician. A copy of the form will be returned to the facility and the original will be retained by the Division in a confidential file.

The Director of the Division of Long Term Care will provide a written final notice of approval or disapproval to the facility for each request for waiver to admit a resident with confirmed or suspected Tuberculosis.

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204

Telephone Number: 317-233-7794
Fax: 317-233-7322

TUBERCULOSIS WAIVER REQUEST
State Form 46595 (R2/3-02)
Indiana State Department of Health-Division of Long Term Care

CONFIDENTIAL: This document contains patient information of a confidential nature.

SECTION I: TO BE COMPLETED BY REQUESTOR

_____
Name of Facility

_____
Street Address

_____ _____ _____
City Zip Code Telephone Number

I hearby request that _____ be admitted to the above name facility. This patient suffers from confirmed or suspected ***Tuberculosis***, a communicable disease. As Administrator of the facility, I certify that the facility is capable of providing proper care for this patient, according to the current guidelines published by the Centers for Disease Control.

_____ _____
Date Signature of Administrator

I, _____, M.D. the Medical Director of the above named facility, request that the patient, who has confirmed or suspected ***Tuberculosis***, be admitted to the facility.

_____ _____
Date Signature of Medical Director

I, _____, M.D. the attending physician for the above named facility, request that the patient, who has confirmed or suspected ***Tuberculosis***, be admitted to the facility.

_____ _____
Date Signature of Attending Physician

SECTION II: TO BE COMPLETED BY DIVISION OF LONG TERM CARE

Based upon the requests made on this form, and with the facility's and medical director's assurance that appropriate precautions to deal with the confirmed or suspected ***Tuberculosis*** has been taken, I hereby grant a waiver to the facility and give them permission for this patient to be admitted.

_____ _____
Date Director, Division of Long Term Care
Indiana State Department of Health

Room Size and/or More Than Four (4) Beds per Room

In accordance with the Health Facilities Rule 410 IAC 16.2-3.1-19 resident rooms must be designed and equipped for adequate nursing care, comfort, and full visual privacy of residents. Requirements for bedrooms must be as follows:

- Accommodate no more than four (4) residents.
- Measure at least eighty (80) square feet per resident in multiple resident bedrooms and at least one hundred (100) square feet in single resident rooms.
- A facility initially licensed prior to January 1, 1964, must provide not less than sixty (60) square feet per bed in multiple occupancy rooms. A facility initially licensed after January 1, 1964, must have at least seventy (70) square feet of usable floor area for each bed. Any facility that provides an increase in bed capacity with plans approved after December 19, 1977, must provide eighty (80) square feet of usable floor area per bed.

General Information

If a facility does not meet the above-mentioned requirements the facility will be cited for the applicable tag number(s) each year during the recertification survey and the post-certification revisit, as applicable. A room size or number of beds per room waiver can then be requested. A waiver is not granted unless it has been cited as a deficiency during the recertification survey, has been recommended for approval by the surveyors, and is supported by appropriate documentation.

Contents of a Waiver Request

A waiver request must include al of the following information/documentation:

- Location of the room in violation of the rule
- Room Type (Residential, Non-Certified Comprehensive (NCC), Medicare, or Medicaid
- Copy of Facility Floor Plan on 8 ½ by 11 paper to show the room numbers and number of beds per room
- Signed statement by the Administrator stating that the health and safety of the residents will not be jeopardized, and that resident's needs are being met.

Submission Requirements

The request should be submitted to:

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204
Telephone: 317-233-7794
Fax: 317-233-7322